AMERICAN **PSYCHIATRIC** ASSOCIATION

IPS: THE MENTAL HEALTH SERVICES CONFERENCE

Oct. 8-11, 2015 • New York City

When Good Care Confronts Red Tape

Navigating the System for Our Patients and Our Practice

New York, NY | Sheraton New York Times Square

FORUM

OCTOBER 09, 2015

EVEN DOCTORS CAN LEARN TO WRITE
Chairs: Lloyd I. Sederer, M.D., Deborah L. Cabaniss, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn the principles and practice of scientific, narrative non-fiction writing for the educated reader ; 2) Experientially see how this is done; 3) Understand the role of social media in disseminating medical writing.

SUMMARY:
Participants will learn the principles and practice of scientific, narrative non-fiction writing for the educated reader.
This workshop is designed for mental health, addiction, and neuroscience professionals â€" including residents, fellows and graduate students, junior and senior clinicians, and scientists - who want to produce brief, written or spoken posts/blogs/articles/reviews for local newsletters and media, regional or state publications, or the national press.
Participants also will learn how to effectively use social media to promote their ideas and writings.

OCTOBER 10, 2015

PUSHING BOUNDARIES AND HEALING HEARTS: THE SHIFTING ROLES OF THE 21ST CENTURY PSYCHIATRIST
Chairs: Erik R. Vanderlip, M.D., M.P.H., Kenneth S. Thompson, M.D.
Presenters: Wesley E. Sowers, M.D., Erik R. Vanderlip, M.D., M.P.H., Kenneth S. Thompson, M.D., Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify key adaptations of traditional psychiatric practice necessary to improving the health status of persons with mental illnesses across a spectrum of practice settings.; ; 2) Critically appraise their current practice environment and healthcare needs of individuals they encounter to allow for delivery of effective healthcare and mental health services.; ; 3) Apply a common framework in clinical assessments to rationalize extension of practice scope to screening and managing general health conditions within the medical neighborhood.; ; 4) Advocate for psychiatry as a subspecialty of medicine able to provide key clinical and policy leadership at the interface of chronic illness, behavioral illnesses and health behavior change.

SUMMARY:
The healthcare system is undergoing a period of intense and rapid change. As reforms catapult providers towards systems which better cater to chronic disease management, clinical roles must adapt to new practice paradigms. Psychiatrists are no exception. A glut of emerging practice models threaten to overwhelm current practitioners who are eager to embrace new skillsets necessary for a new age of psychiatric practice, including general healthcare and collaborative, team-based care. Accurately applied, these skills can improve lives and provide access to desperately needed quality clinical care. However, without clear communication and a ready framework for the application of these skills, work may be duplicated at best or harmful at worst. This workshop will review the skillset needed to carry psychiatry forward within healthcare reform and discuss the application of those skills across a variety of practice settings, highlighting the need for a common framework to assess the shifting role of the 21st century psychiatrist.

EMPOWERING COMMUNITIES TO PREVENT VIOLENT EXTREMISM

WORKSHOP

OCTOBER 08, 2015

PREPARING RESIDENTS FOR THE INTEGRATION OF MENTAL HEALTH AND PRIMARY CARE: WHAT DO RESIDENTS WANT AND HOW CAN WE DELIVER IT?
Chair: Matthew Iles-Shih, M.D., M.P.H.
Presenters: Raj Loungani, M.D., M.P.H., Jason Schweitzer, M.D., Carrie Cunningham, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Give background on current state of residency training/opportunities in mental health and primary care integration; 2) Discuss resident knowledge, attitudes, beliefs regarding integration of mental health and primary care; 3) Provide case examples of training experiences from the perspective of residents and attending mentors from 2-3 programs.

SUMMARY:
Existing research provides strong evidence that Integrated Care can improve outcomes and reduce symptom burden for patients with depression and anxiety who are being treated in primary care settings (Archer et al. 2012). While Integrated Care is increasingly entering into psychiatry residency training, residents receive variable exposure to a range of different integrated models and theoretical underpinnings. This session will focus on how residencies can prepare new generations of providers for emerging opportunities in the integration of mental health and primary care. It will be co-led by residents, with additional contributions by select attending physicians who have been leaders in their institutions with respect to training in Integrated Care.
The session will be composed of four sections, accounting for approximately 15, 20, 50, and 15 percent of the total time, respectively. First, we provide an overview of the current state of residency training in Integrated Care. Secondly, we discuss resident knowledge, attitude, and beliefs regarding integration of care, based on the results from a multi-program resident survey.
Then we leverage the breath of our panel members to discuss institutional and individual experiences, and what might be learned from these. Specific curricula and training opportunities discussed will include: those of the University of Washington, with a particular comparative focus on resident experiences within co-located integrated care models (BHIP) vs large-scale registry-based collaborative care (MHIP); Cambridge Health Alliance, presenting on the residency curricula in Integrated Care, a longitudinal third year rotation in co-located mental health in primary care, and fourth year elective opportunities in co-located care in specialty medical settings; potential resident experiences in Brooklyn within integrated care medical care home in Behavioral Health building for mental health services at Kings County Hospital & Clinics, as well as in STAR Health Center for integrated specialized services for those with HIV, Hep C, and substance abuse disorders at SUNY-Downstate University Medical Center; opportunities at the Harvard Longwood Psychiatry Residency Training Program, including resident exposure to collaborative and reverse co-located models.
Finally, the session with end with an integrative discussion among panel and audience regarding "ways forward" for resident training in integrated care.

PROMOTING PHYSICAL WELLNESS IN YOUNG ADULTS WITH NEWLY DIAGNOSED SERIOUS MENTAL ILLNESSES
Chair: Beth Broussard, C.H.E.S., M.P.H.
Presenters: Sean T. Allan, M.D., Michael L. Birnbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss physical health interventions in an early intervention framework; 2) List two of the five-year targets set out by the HeAL consensus statement; 3) Utilize the HETI Positive Cardiometabolic Health Algorithm with a case example.

SUMMARY:

Young people experiencing a serious mental illness for the first time are at an increased risk of poor health outcomes and face a shortened lifespan of 25 years on average (Parks et al., 2006). For example, those experiencing their first episode of psychosis are at an increased risk of weight gain (Britvic, et al., 2013), cardiovascular disease and diabetes (Graham, Cho, Brownley, & Harp, 2008; Patel, et al., 2009), and often present with significant medical comorbidities (Strakowski, et al., 1993). Smoking, poor dietary choices, infrequent physical activity, and side effects from antipsychotic medications are some of the factors thought to account for the elevated levels of physical morbidity among this population (Deng, 2013). This workshop will discuss how to address physical health in early intervention services and present the latest guidelines for monitoring young adult patients, in terms of prevention of physical health issues. We will also present results of a qualitative study, which examined the subjective perceptions of physical health and its relation to mental health in adolescents and young adults admitted to the Early Treatment Program (ETP) for psychosis in New York.

USING LEARNING COLLABORATIVES TO ENHANCE IMPLEMENTATION AND DISSEMINATION OF SUPPORTED EMPLOYMENT IN NEW YORK STATE
Chair: Leslie Marino, M.D., M.P.H.
Presenter: Paul J. Margolies, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the components of Individual Placement and Support as an evidence-based practice for supported employment; 2) Discuss factors related to implementation of IPS as an evidence-based practice across a large and diverse mental health system using a learning collaborative model; 3) Understand how to use the REAIM framework to evaluate implementation and outcomes of an intervention.

SUMMARY:
Individual Placement and Support (IPS) is an effective intervention for increasing competitive employment rates among individuals with severe mental illness.1 Competitive employment rates in New York State have historically been low, roughly 10%. In January 2013, the Office of Mental Health in New York State and the Center for Practice Innovations at New York State Psychiatric Institute initiated a plan to utilize a learning collaborative as a means to drive implementation, increase program fidelity in IPS and improve employment outcomes. Research on learning collaboratives is sparse, although the few studies conducted have demonstrated their efficacy in quality improvement initiatives for treatment of medical illnesses and in primary care settings.2 By 2014, 59 programs (69% of those eligible) in New York State had voluntarily entered the learning collaborative which provided both face-to-face and online training and support activities. The purpose of this workshop will be to present data on outcomes of the state-wide implementation of IPS using the REAIM framework (Reach, Effectiveness, Adoption, Implementation, Maintenance) for evaluation and to discuss highlights and challenges of implementing an evidence-based practice in a large and geographically diverse state.
1. Drake RE, Bond GR, Becker DR: Individual placement and support: An evidence-based approach to supported employment. New York, Oxford University Press, 2012.
2. Schouten L, Hulscher ME, van Everdingen JE, Huijsman R, Grol RP. Evidence for the impact of quality improvement collaboratives. BMJ 2008;336:1491-4.

A TALE OF TWO RESIDENCIES: DEVELOPING RESIDENT LEADERS IN CULTURAL PSYCHIATRY
Chair: Chuan Mei Lee, M.A., M.D.
Presenters: Akhil Mehra, M.D., Ph.D., Rubiahna Vaughn, M.D., M.P.H., Helena B. Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will appreciate why specialized training in cultural psychiatry is needed to meet the needs of diverse patient populations.; 2) Participants will describe the multiple steps taken by two academic residency programs in its development of specialized training in cultural psychiatry.; 3) Participants will develop ideas for designing similar training opportunities in cultural psychiatry at their home institutions including active discussion of the challenges and opportunities.

SUMMARY:
Specialized training in cultural psychiatry during psychiatry residency offers residents the skills and resources to meet the mental health needs of diverse patient populations. Two academic residency programs, UCSF and NYU, have each taken steps to incorporate cultural psychiatry training in their respective curricula. The UCSF Adult Psychiatry Training Program developed a Cultural Psychiatry Area of Distinction in order to provide an elective training experience to prepare leaders in cultural psychiatry and foster applications in everyday clinical practice, research, and teaching. Participating residents receive one-on-one faculty mentoring, attend group conferences, review a cultural psychiatry knowledge base, develop scholarly projects, undertake self-reflection, and present educational material to near peer learners.

The NYU Residency Training Program in Psychiatry has a cultural psychiatry curriculum with required didactics in the PGY1, PGY3 and PGY4 years, covering interviewing skills, community based psychiatry, and the culture of psychiatry with respect to the politics and economics of mental health care. It also includes a PGY 4 elective in public psychiatry. This curriculum is supplemented by a quarterly dinner seminar series hosted by the NYU Association for Culture & Psychiatry. Experts on "The Cross-Cultural Therapeutic Dyad," "Intersections of Race, Sexual Orientation and Gender Identity," "The Hasidic Community and Psychiatry," and "Multicultural Issues in Working with Survivors of Torture" have shared their knowledge in an informal setting open to all NYU residents. This workshop seeks to be a conversation that offers models for other residency training programs wishing to develop similar cultural psychiatry curricula.

PSYCHIATRISTS AS LEADERS: BRINGING ORGANIZATIONS AND DISCIPLINES TOGETHER THROUGH EFFECTIVE BOUNDARY SPANNING
Chairs: Patrick S. Runnels, M.D., Serena Y. Volpp, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe and understand boundary spanning as a concept ; 2) Identify core advantages of focusing on boundary spanning as a management strategy; 3) Recognize challenges inherent in the boundary spanning role and strategies for managing those challenges; 4) Apply boundary spanning concepts to real situations in their current work environments; 5) Identify the benefits of broader leadership training as put forth in public and community psychiatry fellowships.

SUMMARY:
With the passage and implementation of the Affordable Care Act, the burden to our systems of mental health care is likely to grow, increasing the demand for capable and innovative leaders. Consequently, many current practitioners are likely to be offered leadership opportunities in the coming years. Yet, clinicians receive almost no formal leadership training and many individuals who are promoted to leadership positions struggle as a result. Public and Community Fellowships are among the only training programs in the country that offer intensive formal leadership training for physicians, but few people have any sense of what that training is like. Here, we will focus on one area of leadership to better demonstrate the overall value of such fellowships. Boundary spanning - the term used to describe the role of individuals from one organization or discipline who meaningfully engage individuals from different organizations and disciplines - is inherent to the work of psychiatrists and other clinicians who practice in almost any organized setting, particularly those inhabiting leadership roles. Yet few people understand the power of embracing this concept and the downfalls of poorly executed boundary spanning. The presenters will demonstrate in vivo how this concept is taught to the fellows in their programs and offer attendees the opportunity to discuss issues related to boundary spanning in their own environments.

A COGNITIVE BEHAVIORAL APPROACH TO WEIGHT LOSS AND MAINTENANCE
Chairs: Judith Beck, Ph.D., Deborah Beck Busis, L.C.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Teach dieters specific 'pre-dieting' cognitive and behavioral skills;; 2) Keep motivation high long-term; 3) Facilitate permanent changes in eating.

SUMMARY:
A growing body of research demonstrates that cognitive behavioral techniques are an important part of a weight loss and maintenance program, in addition to exercise and changes in eating (see, for example, Stahre & Hallstrom, 2005; Shaw, 2005; Werrij et al, 2009, Spahn et al, 2010; Cooper et al, 2010). An important element that is often underemphasized in weight loss programs is the role of dysfunctional cognitions. While most people can change their eating behavior in the short-run, they generally revert back to old eating habits unless they make lasting changes in their thinking. This interactive workshop presents a step-by-step approach to teach dieters specific skills and help them respond to negative thoughts that interfere with implementing these skills every day. Participants will learn how to engage the client and how to solve common practical problems. They will learn how to teach clients to develop realistic expectations, motivate themselves daily, reduce their fear of (and tolerate) hunger, manage cravings, use alternate strategies to cope with negative emotion, and get back on track immediately when they make a mistake.

Techniques will be presented to help dieters respond to dysfunctional beliefs related to deprivation, unfairness, discouragement, and disappointment, and continually rehearse responses to key automatic thoughts that undermine their motivation and sense of self-efficacy. Acceptance techniques will also be emphasized as dieters come to grips with the necessity of making permanent changes and maintaining a realistic, not an "ideal" weight that they can sustain for their lifetime.

PSYCHIATRIC ASSESSMENTS: GOING BEYOND DSM 5 AND MEDICATION EVALUATIONS
Chair: Mark Ragins, M.D.
Presenter: John Santopietro, M.B., Kenneth Minkoff, M.D., Robert P. Liberman, M.D., Charles W. Huffine, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To have an appreciation of the limitations of DSM 5 and medication evaluations as a foundation for collaborative services.; 2) To understand some specific alternatives to syndromic diagnoses, including clinical formulations and clinical and cultural explanations, that can form the basis for a shared understanding with our patients of their condition .; 3) To assess barriers to engagement, trust, and collaboration and use specific skills to overcome those barriers, including for adolescents.; 4) To use specific tools for recovery oriented and integrated assessment including client's strengths, interests and goals to create a strong foundation for collaborative, team based service plans.

SUMMARY:
Many psychiatrists find themselves in the position of focusing their assessments on DSM 5 diagnoses and medication evaluations, relying on other, often lesser trained and experienced, staff for additional assessments, and then approve and sign team treatment plans. While this process efficiently gets all the required paperwork done, does it really lead to individualized, collaborative, effective service delivery? This symposium takes a deeper look at what's necessary within an assessment process and how psychiatrists can most effectively contribute.

While it's widely clinically recognized that more is needed to effectively help people than a broad syndromic diagnosis and medications (for example, understanding people's barriers to forming a trusting collaborative relationship, creating a shared story - a formulation - of their condition, understanding their goals, strengths and motivations) psychiatrists don't often focus our assessment time and efforts upon these crucial components.

Section one will begin with a broad discussion of the clinical limitations of DSM 5 as a tool for understanding people and forming treatment plans. Then we'll propose specific enhancements (moving from diagnoses to formulations and incorporating clinical and cultural explanations) to make assessments more accessible to our patients.

Section two will focus on the need to engage people both to get the information we need and to establish the beginnings of a colloabative relationship. We will use the Recovery to Practice Engagement and Welcoming Environments to highlight common barriers and approaches to overcome them in the assessment phase of treatment.

Section three will focus on the practicalities of "Recovery Oriented and Integrated Assessments" (ILSA) and "Client's Assessment of Strengths, Interests & Goals" both highly developed approaches for building team based collaborative services.

Section four will describe how to integrate these various approaches and adapt them to the special needs of treating adolescents.

Our discussion will focus on how incorporating these approaches can help bring the "clinical soul" to our assessments and our systems.

HIGH INTENSIVE CARE: BACKGROUND, RATIONALE, MODEL, AND EFFECTS
Chairs: C.L. Mulder, M.D., Tom van Mierlo, M.D.
Presenters: Bram Berkvens, B.A., Joris F. Hendrickx, M.D, C.L. Mulder, M.D., Tom van Mierlo, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To inform the audience about a new concept of an (in)voluntary admission ward for severely mentally patients in psychiatric crisis: the High & Intensive Care (HIC) ; 2) To present how the recovery oriented and medical model can both be used in the High & Intensive Care, aiming at minimizing coercion and promotion of recovery ; 3) To present data on HIC model fidelity and its associations with outcome; 4) To present consumer and professional experiences with the High & Intensive Care model .

SUMMARY:
The High & Intensive Care (HIC) is a new concept of an (in)voluntary admission ward for severely mentally ill patients who are in a psychiatric crisis. The admission unit is based on the recovery oriented as well as the medical model.

Outpatient clinicians and caregivers are involved in the admission and treatment process. A variety of practice- and evidence based practices are used to optimize treament and to prevent coercion, including investing in intensive contact with patients direct from the beginning of the admission ("The first five minutes"), involvement of caregivers (sleeping in), use of crisis plans, shared decision making, risk assessment, medication, consumers in the team, psychosocial treatments and non-verbal therapies. When patients are in severe crisis, 1-to-1 guidance can be provided by specialized nurses; in extreme situations, patients can be secluded in a special room, where they are not left by themselves. An HIC model fidelity scale was developed and tested to assess the degree to which all elements of the HIC model have been implemented; in addition the associations between HIC model fidelity and outcome (use of coercive measures) will be presented.

During the symposium we will present the rationale for the HIC model, as well as experiences from clinicians and consumers, followed by results of a nation wide study in 20 wards on the associations between HIC model fidelity and outcome.

OUTCOMES OF ASSISTED OUTPATIENT TREATMENT: WHAT CORRELATES WITH POSITIVE OUTCOMES?
Chair: Scott Soloway, M.D.
Presenters: Serena Y. Volpp, M.D., M.P.H., Daniel Garza, M.D., Paulina G. Marsh, M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Summarize the results of major outcomes studies of assisted outpatient treatment (AOT) and similar programs nationwide.; 2) Articulate the main findings of the New York City AOT Program's review of post-court order outcomes.; 3) Recognize the role of court-mandated treatment in the recovery of consumers with mental illness.

SUMMARY:
With the proliferation of media reports about mass shootings in the past few years, court-mandated treatment has become a popular "solution" to the problem of violence in the public imagination. However Assisted

Outpatient Treatment (AOT), also called outpatient civil commitment, involuntary outpatient commitment, or court mandated outpatient treatment remains a source of controversy in the mental health community. Perceptions of AOT range from an unduly coercive imposition of governmental power to a necessary first step for some individuals on their journey towards recovery. The New York City AOT program was established in 1999 and has coordinated care and treatment for thousands of consumers. Unfortunately because the AOT program has historically only followed these individuals while under court order, the crucial question of how consumers fare after AOT ends has been difficult to answer. This question is now better able to be addressed with the incorporation of information from the New York State Medicaid database into the AOT program's ongoing quality improvement and performance evaluation activities. The Medicaid database provides information on hospitalizations, outpatient visits and filled prescriptions. For this discussion, we will review information for individuals with AOT court orders that ended in fiscal year 2012 or later. The review will look to see how successfully engaged in treatment consumers are after the order ends and whether or not the status at the time of termination as well as demographic and diagnostic factors were related to success or failure. After reviewing both the literature on AOT outcomes and the more recent de-identified data we will discuss how consumers fare after the AOT order ends and what the correlates are of various outcomes. These presentations will be used to catalyze an audience discussion of AOT outcomes and the role of AOT in recovery.

PSYCHIATRISTS AT THE UN: HOW TO FILL THE GAP
Chairs: Farah Herbert, M.D., Mardoche Sidor, M.D.
Presenters: Vivian Pender, M.D., Maninder S. Bhutani, M.B.B.S., Xiaojue Hu, M.D., Anil A. Thomas, M.D., Jose Vito, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize how psychiatrists can partner with the United Nations system, including its agencies and member states, and interact with non-governmental organizations working with the UN system.; 2) Discuss how to help the UN work to ensure humane, effective and high quality treatment for all persons with mental disorders, including intellectual disorders and substance abuse disorders.; 3) Assist with bringing international issues and concerns of the United Nations to members of psychiatric profession in different areas of the United States and globally.

SUMMARY:
The United Nations is an international organization founded in 1945 that does work reaching every corner of the globe. The organization affects the status of the world through efforts in social development, sustainable development, environment and refugees protection. It also helps with disaster relief, counter terrorism, disarmament and non-proliferation, promoting democracy, human rights, gender equality and the advancement of women, governance, economic and social development and international health, clearing landmines, expanding food production, and more. The American Psychiatric Association working through the New York County Psychiatric Society established itself as a non-governmental organization (NGO) to partner with the myriad UN systems to develop programs that can help ensure that all persons with mental disorders receive humane, effective and high quality treatment. By attending regular meetings of the UN, and participating in the work of larger Commissions, Agencies, Committees and Regions, psychiatrists can identify areas where service gaps could develop and help educate others about the needs and available resources to help diverse populations, including women, children, the poor and survivors of natural and man-made disasters and conflicts, across the globe. In its position as an NGO, the APA is able to grant access to the UN for APA members to take an active role in advocacy and education as well as being present to share first-hand information with colleagues about the actions of the UN that have an impact on global mental health. The committee of the NYCPS that first became involved in this work will share insights during small group breakout sessions about working with a global organization with diverse missions, including how to explore individual interests in relation to the status of women, children and substance use within the framework of the UN.

TELLA-FELLA: USING ONLINE COMMUNICATION TO REMOTELY TRAIN PUBLIC/COMMUNITY PSYCHIATRY FELLOWS
Chairs: Stephanie LeMelle, M.D., Patrick S. Runnels, M.D.
Presenters: Ashley M. Overley, M.D., Mardoche Sidor, M.D., Steve Koh, M.D., M.P.H., Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) 1)The ACA and integrated care have increased the demand for well-trained community psychiatrist. To meet this increased demand, participants will explore ways to expand workforce development; 2) 2)There are currently 16 Community Psychiatry Fellowships nationally. Participants will discuss models for remote learning through the use online communications to increase access to these fellowships; 3) 3) There are many types of online platforms for remote learning. Participants will discuss the pros and cons of the different platforms for fellowship training.

SUMMARY:
According to the National Association of State Mental Health Program Directors, 6.8 million uninsured people with a mental illness will gain coverage through the federal and state health insurance exchanges. With this new public population, the push for integrated care, treatment of co-occurring disorders and the need to take a system based approach to the complexities of our mental health delivery systems, we need to have well-trained community psychiatrist. There are currently 16 Public/Community Psychiatry Fellowships (PPF) doing this type of training nationally. PPF programs are now trying to expand their training capacity and possibly creating new fellowships by using online communication and remote learning techniques. There are several models and different technologies available. This workshop will focus on the pros and cons of the different models of remote learning and discuss the practical use of online technology.

EDUCATIONAL JOURNEYS: RESIDENT, ATTENDING, AND CONSUMER PERSPECTIVES ON LEARNING AND TEACHING ABOUT RECOVERY
Chair: Michelle T. Joy, M.D.
Presenters: Michelle T. Joy, M.D., Lawrence Real, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To recognize opportunities and obstacles to learning about recovery for psychiatry residents and other provider; 2) To learn different methodologies for teaching providers about recovery-oriented car; 3) To understand the perspective of persons with lived experience in teaching recovery to peers; 4) To apply practical and multifaceted strategies to teaching principles of recovery.

SUMMARY:
Recovery-oriented treatment for mental health problems has received increased attention in recent years. Effectively teaching recovery principles to providers and people aspiring to be 'in recovery' is important in facilitating further implementation of recovery-oriented practice across the landscape of mental health care. This workshop will begin with a basic overview of the principles of recovery-oriented care, for those new to the concept or desiring a refresher. This will be followed by a collaborative presentation on learning and teaching about recovery in different clinical settings. Experiences with APA/AACP's Recovery to Practice curriculum, narrative medicine exercises in mental health, modeling behaviors, and other practical clinical techniques will be presented. Discussants will include a psychiatric resident, a community psychiatry fellowship director, and a person with lived experience, who will share clinical histories and personal anecdotes, illustrating potentially effective strategies. Participant comments and questions will help to generate practical approaches to teaching and practicing recovery-oriented care, both in residency and beyond.

RISK MANAGEMENT AND PSYCHIATRY
Chair: Kristen Lambert, Esq., M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore common claims against psychiatrists and other behavioral health providers; 2) Discuss current trends in litigation against psychiatrists; 3) Explore issues with documentation and its impact on lawsuits; 4) Examine liability issue and risk reduction strategies.

SUMMARY:
Psychiatrists spend 3% of their careers dealing with an unresolved liability claim. The impact when and if a psychiatrist is sued can be significant. It can impact the psychiatrist's practice and life over a number of years. This presentation provided by risk management for the APA-endorsed liability carrier will explore common claims, discuss current trends in litigation against psychiatrists, explore issues with documentation and its impact on lawsuits, examine liability issues, provide case examples and identify risk management strategies which could have been implemented to minimize risk.

OCTOBER 09, 2015

GUN CONTROL AND PSYCHIATRY: EXPLORATION OF THE ROLE OF PSYCHIATRISTS IN ENSURING PUBLIC SAFETY
Chairs: Olaya L. Solis, M.D., Elissa Benedek, M.D.
Presenter: Lisa M. Anacker, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify responsibilities that mental health providers have in assessing risk to patient and others; 2) Develop an awareness of legal limitations that psychiatrists have on trying to restrict gun ownership in their patients; 3) Learn about how different states have taken measures to limit gun control by patients with diagnosed mental illness; 4) Engage in discussion about positive impact we can have on the general public's understanding of psychiatric illness and to help correct false ideas about mental illness and violence.

SUMMARY:
Gun control is a controversial topic, particularly when gun control laws are targeted at individuals with mental illness. Some states have enacted laws that are meant to identify and limit gun ownership by any person who is being treated for mental illness, whereas other states are remiss to even report patients to registries despite laws that are already in place. Furthermore, the general public not only looks to psychiatrists to predict human behavior but also has an expectation that we can stop acts of violence, particularly those perpetrated by gun owners. In this workshop, the presenters will provide the audience with facts about gun control laws in various states, so that the audience can appreciate the spectrum of gun control laws. They will also highlight the balance that psychiatrists must strike in conducting risk assessments and trying to minimize access to firearms in patients who have shown a predisposition towards violence to self or others and respecting a Constitutional right. They will also share will also share with the audience their own professional experiences in managing patients with access to firearms and the limitations they have faced when trying to limit their access. One of the major points will be that there are other conditions that may have more impact on violence than mental illness alone, with the proposal that gun control laws may be best targeted at other populations than those with mental illness alone.

CANNABIS: WHAT CLINICIANS NEED TO KNOW
Chairs: Brian Hurley, M.B.A., M.D., John Douglas, M.B.A., M.D.
Presenters: Kevin P. Hill, M.D., M.H.S., Brian Hurley, M.B.A., M.D., John Douglas, M.B.A., M.D., Petros Levounis, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the signs and symptoms associated with both cannabis intoxication and withdrawal; 2) Differentiate between the many cannabis-related products and routes of administration; 3) Organize and focus a differential diagnosis when cannabis use co-occurs with other psychiatric symptoms and conditions; 4) Summarize the evidence of the risks and benefits associated with

the use of cannabis and related agents; 5) Discuss the history of cannabis's legal statuses, describe current legal trends, and anticipate the psychiatric impacts associated with these legal trends.

SUMMARY:
Cannabis sativa is the plant whose leaves are dried to make marijuana. This plant is used both medically and recreationally by an increasing number of Americans. To date, twenty three states and the District of Columbia have legalized cannabis for medical use, and four states and the District of Columbia have legalized cannabis for recreational use. In this evolving legal landscape, cannabis use has become increasingly prevalent, particularly among teenagers and young adults. Nine percent of adult and seventeen percent of adolescent cannabis users have been found to develop addiction to cannabis. In this context, community and public psychiatrists are on the front-lines in addressing the psychiatric consequences associated with the changing landscape of cannabis use. Further, there are policy opportunities now evident from the experience of states where cannabis is decriminalized or legalized to amplify the benefits and mitigate the drawbacks to these legal approaches. The role of community and public psychiatrists as advocates for scientifically-informed public policy will be emphasized during this session.

This session will introduce the major forms of cannabis related-products for recreational use which include marijuana, hashish, hash oil, and synthetic cannabinoids. The intoxication effects, physical signs, and the pharmacology of these products will be discussed. Evidence of the long-term adverse effects and known medical benefits of various cannabis-related products, including current FDA approved medications will be summarized. The prevalence of cannabis use among various subpopulations will be reviewed. This session will also demonstrate how to assess and manage cannabis intoxication and withdrawal, and approach the treatment of cannabis use disorders. The presenters will discuss when cannabis use disorder should be considered in the differential diagnosis of patients with psychiatric symptoms. Given the widespread use and evolving legal policies surrounding the use of these cannabis-related products, a review of our current state of knowledge has important implications for educators, clinicians, and policy makers.

This workshop will use a case example to illustrate clinical assessment and treatment options for patients who use cannabis and have other psychiatric symptoms. Audience members will be invited to participate in a facilitated case discussion and asked to identify a differential diagnosis, identify what additional data they would seek to help narrow their differential diagnoses, and select which treatment approaches they would utilize to manage common cannabis-associated clinical features. A facilitated discussion involving the presenters and workshop attendees will critique the assessment and management of the case along with highlighting critical implications for clinical practice, research, and public health.

CULTIVATING CONNECTIONS: ADAPTING MOTIVATIONAL INTERVIEWING TO PHONE CRISIS WORK
Chairs: Elizabeth A. Sysak, Ph.D., Alin J. Severance, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) recognize and understand unique challenges working in a psychiatric phone crisis center; 2) understand motivational interviewing and how it may be benefit clinical work in a crisis setting; 3) understand and apply different interactive teaching and supervision methods to support effective use of motivational interviewing in clinical interviews in a crisis setting; 4) understand and identify different qualitative and quantitative methods of measuring impact to evaluate the positive and negative effects motivational interviewing has in clinical work in a crisis setting.

SUMMARY:
Millions of people utilize phone crisis centers for themselves or loved ones who may be in need of additional support. People who are in a psychiatric emergency or any perceived crisis have found phone crisis hotlines to be particularly helpful. The number of individuals who find safety in calling crisis hotlines has grown significantly over the last decade. People take comfort in the anonymity that the phone provides and at the same time seek a connection with another human to work through whatever concern might be plaguing them in their day to day routine. Ultimately, people call into crisis lines because they want to connect. People want someone to pick up the phone and know that there is someone on the other line who cares and will listen. Organizations are always trying to find better ways to making sure people are feeling connected and heard. Motivational Interviewing offers the

non-judgmental and supportive language necessary to meet people where they are while providing a collaborative and empathic intervention.Motivational interviewing (MI) is a brief treatment approach, traditionally used to help patients with substance abuse develop and increase their intrinsic motivation to change addicting behaviors. MI was originally designed for working with challenging patients who may not have demonstrated strong commitment to treatment or recovery and often displayed a level of ambivalence about whether to engage in treatment or not. Over the past decade professionals in the medical and clinical setting have found motivational interviewing in a variety of contexts, but never before in the crisis setting. This workshop introduces how the use of MI can be used in a crisis setting with different patient presentations. Motivational Interviewing is a non-judgmental, non-confrontational approach to increase a client's internal motivation and resolve ambivalence by exploring the pros and cons of change. This workshop illustrates a few interactive methods that proved to be helpful for the crisis setting. In addition to training and continued practice, supervision was vital in supporting and enhancing skills and techniques within the motivational interviewing framework. This workshop will explore the use of supervision and training to help clinicians' and psychiatrists professional growth and development in order to better connect with the consumers we serve. There has been minimal research published on MI in crisis work and we have worked over the past year and half to produce outcomes that have given evidence that using Motivational Interviewing can have a strong impact on consumers and staff in crisis clinical interactions.

WERE YOU TOTALLY SATISFIED WITH YOUR EXPERIENCE TODAY? CUSTOMER SERVICE AS FUEL FOR RECOVERY TRANSFORMATION

Chairs: Sacha Agrawal, M.D., M.Sc., Michael J. Sernyak, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Outline the essential elements of good customer service; 2) Describe how improving customer service can facilitate recovery transformation; 3) Identify improvements that can be made in his/her own workplace to improve the experience of service-users.

SUMMARY:
Customer service is fast-becoming an important paradigm for healthcare in North America. Borrowing from lessons learned in other service sectors, both for-profit and non-profit private sector healthcare administrators are targeting high patient satisfaction as a way of increasing customer loyalty and increasing revenue. We argue that customer service is also a critical and under-emphasized dimension of quality in public sector behavioural health that could accelerate systems transformation to a recovery orientation. In this interactive workshop, we will describe the concepts of customer service, customer experience and customer satisfaction by drawing on examples from participants' everyday lives as customers. Next we will review the academic literature on patient satisfaction in healthcare, highlighting its potential value and also the conceptual and methodological problems that remain. We will then consider how a customer service focus can facilitate the transformation of behavioral health to a recovery orientation. Our experiences at the Connecticut Mental Health Center (New Haven, CT) and the Centre for Addiction and Mental Health (Toronto, Canada) will serve as a springboard for discussing 4 tips for supporting recovery by improving customer service.

LONG-TERM CARE MANAGEMENT OF PATIENTS WITH HIV
Chair: Marshall Forstein, M.D.
Presenters: Lawrence M. McGlynn, M.D., Kenneth Ashley, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn techniques to diagnose and effectively manage cognitive impairments in patients with HIV; 2) Understand the impact of aging as it relates to treating patients with HIV ; 3) Understand the impact of tobacco use and tobacco cessation on patients with HIV.

SUMMARY:

With the advent of multi drug therapy to suppress HIV, the life expectancy for patients with HIV has increased, changing HIV - into a "chronic condition". Health care providers have to transition to a model of care to manage a patient's treatment over the long-term. With this new understanding, psychiatrists will need to effectively manage a patient's cognitive function in order for them to adhere to treatment plans and live longer lives. Furthermore, aging and tobacco use are becoming emerging topics of interest in HIV care as they increase morbidity , and should be considered when undergoing long-term care management with a patient with HIV.

This session will provide tools for healthcare providers to continually assess and stabilize cognitive function and improve overall health, especially with taking aging and smoking cessation into consideration when treating patients with HIV. The session will include lectures on long-term care management followed by an interactive question and answer period providing participants the opportunity to discuss individual clinical concerns. Discussion will include how to discuss coping with HIV cognitive impairment in the context of psychotherapy.

TELEPSYCHIATRY: DELIVERING A NOVEL USE OF AN ESTABLISHED TECHNOLOGY FOR MENTAL HEALTH SERVICES IN A MINORITY AND DIVERSE POPULATION IN AN URBAN SETTING
Chairs: Jose Vito, M.D., Matthew D. Erlich, M.D.
Presenters: Hudson Elmore, M.D., Jean-Pierre Lindenmayer, M.D., Rubiahna Vaughn, M.D., M.P.H., John Kasckow, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participants should be able to recognize the benefits and challenges of using telepsychiatry in an urban setting among an ethnically diverse patient population; 2) Identify methods of fostering engagement among the seriously mentally ill patient population; 3) Discuss the role of telepsychiatry as a learning tool in educating trainees. .

SUMMARY:
Telepsychiatry has been used for many years from child to geriatric populations; in the emergency setting to home consultation; and with a diversity of ethnic groups. One of the most widely used and researched aspects of telepsychiatry is that of dispensing care to patients living in remote, rural settings with few local psychiatrists. However, its potential uses have expanded as technology has improved, costs have decreased and evidence has mounted to support its use. Accordingly, this workshop will discuss an innovate use for telepsychiatry: that of fostering engagement in an ethnically diverse, urban patient population in New York City.

One of the ongoing challenges confronting the field of psychiatry is that of disengagement from care, particularly among patients with serious mental illness (SMI) and underserved minority populations. Patients are particularly vulnerable to discontinuation in services when transitioning between levels of care, such as after discharge from the inpatient setting. As "reaching out" techniques (e.g. meeting with outpatient staff prior to discharge), have been shown to improve follow-up but are often not feasible, presenters believe telepsychiatry can provide an alternative means to foster engagement prior to transitioning to the outpatient setting.

In addition, this workshop will discuss the use of telepsychiatry for the purposes of graduate medical education, including exposure of residents to minority, urban, SMI patient populations.

PSYCHIATRIC ADVANCE DIRECTIVES: STATEGIES FOR IMPLEMENTATION AND ENGAGEMENT
Chair: Rachel Zinns, Ed.M., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will be be able to use Psychiatric Advance Directives in clinical settings for engagement and strengthening alliance.; 2) Participants will be able to anticipate common barriers to implementation of Psychiatric Advance Directives.; 3) Participants will be able to identify systems-based strategies for successful implementation of Psychiatric Advance Directives (PAD).

SUMMARY:
Consumer autonomy, improved treatment adherence, enhanced treatment alliance, and reduced violence are among the many supposed benefits of psychiatric advance directives (PAD). Despite reports of these and other

benefits of PAD, strong consumer interest in PAD, and national policy oversight moving towards a standardization of PAD, their use has not been widespread. Indeed, there have been numerous reports in recent years of consumer and clinician attitudes regarding PAD, content of PAD documents, and factors related to their completion process. Yet little has been written about the implementation of PAD at the individual or organizational level.

In this presentation, I will review national regulations aimed at promoting PAD use as well as several examples of "successful" systems-based implementation plans. I will explain how these regulatory and systems-based strategies are failing to lead to PAD utilization, using both evidence from the literature about how people create PAD, as well as outcomes from surveys of providers and consumers in a large State hospital system of outpatient clinics and ACT teams.

As clinician attitudes about PAD have been shown to be a strong predictor of consumer interest in and completion of PAD, I will report on a current initiative to focus implementation efforts on clinician engagement. I will give real examples of PAD being incorporated into ongoing treatment and present a model for using PAD as a clinical tool for engagement and alliance-building.

A PSYCHIATRY RESIDENT'S VIEWPOINT: ESTABLISHING AN HIV PSYCHIATRY COLLABORATIVE CARE PROJECT IN THE SOUTHEASTERN UNITED STATES
Chair: Daena L. Petersen, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the project method for embedding psychiatric services in an outpatient HIV clinic within an academic center; 2) Understand key factors in increasing collaboration between psychiatric, HIV, and community services, including community mental health; 3) Describe an example of inpatient consult liaison linkage services to HIV positive patients with significant psychiatric problems.

SUMMARY:
A significant proportion of HIV positive individuals in the Charleston, SC region, who receive outpatient medical care have co-morbid mental health problems. These individuals often demonstrate sub-optimal compliance, including inconsistent HIV medication adherence, missing medical appointments, and high rates of hospitalization related to HIV/AIDS. Their health condition is significantly complicated by their mental health problems, including depression, anxiety, bipolar disorder, alcohol and drug use, and psychosis. Unfortunately, a high proportion of these individuals similarly go without adequate mental health care. Furthermore, they often suffer from disparaging attitudes regarding their diagnosis, sexual orientation and gender identity, which may lead to self-loathing and poor self-care in terms of health. A large proportion of individuals choose to deny their risk for HIV/AIDS and go without HIV testing, which puts others at high risk for infection. This dynamic has been realized through South Carolina's status as first in the nation with highest rates of heterosexual transmission among 50 states and DC.

In response to the needs of this vulnerable population in South Carolina, an HIV Psychiatry Project was created with three objectives. First, to embed psychiatric services in the outpatient HIV clinic in an academic center. Second, to establish collaborative clinical care between the traditional university health system HIV services, psychiatry services, and community health organizations. Third, to establish an inpatient consult-liaison linkage service for HIV positive patients with significant psychiatric problems hospitalized for HIV/AIDS related concerns.

This workshop will consist of two 45-minute segments, aimed at elucidating a resident's role in spearheading this program in all three contexts, and highlighting what lessons this may provide for other clinicians. The second half will be an interactive discussion as well as a question and answer session with the workshop participants.

DOCUMENTATION IN THE EHR ERA: FROM DENIAL TO MASTERY
Chair: Judith F. Kashtan, M.D.
Presenters: Paul Stuart Appelbaum, M.D., Lori Simon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) What to include and/or omit in clinical notes to satisfy documentation requirements of insurers, medical boards and minimize malpractice risks; 2) How to fulfill above requirements with effective coding and templates; 3) How do so using EHR's selection process, use of templates.

SUMMARY:
During the past several years, mental health providers have experienced an increasing burden of documentation requirements imposed by federal and state agencies, medical boards, and insurers. These include mandated EHR's, electronic prescribing, more complex coding, and tracking of outcome measures. As a result, many providers are feeling increasingly overwhelmed and frustrated by the amount of time spent on documentation. Some older providers are even resorting to leaving their practices.

The goal of this symposium is to provide practitioners in both private practice and institutional settings with a clear understanding of what documentation is now required and how to go about successfully satisfying those requirements, while maximizing the quality time spent with their patients. Dr. Kashtan will begin the symposium with a brief presentation framing these challenges by relating her journey attempting to implement the new requirements imposed by her home state (Minnesota), including the need to use an EHR for all documentation. The first section of the symposium will be an indepth discussion of the legal and financial/insurance related requirements for documentation, as well as the purpose of documentation for practitioners, themselves. Dr. Appelbaum will review current law in regard to satisfying all legal requirements and avoiding malpractice risk, as well as discuss the issues surrounding patient privacy. Dr. Simon will provide an overview of the documentation needed to support the new coding requirements for billing that were implemented in 2013. Dr. Kashtan will conclude this section by discussing the importance of documentation for practitioners' own use.

The second session will include discussions by both Drs. Simon and Kashtan on the actual format of notes. Dr. Simon will then discuss methods to implement those note formats in actual practice, especially within EHRs, as well as how to go about first selecting the most appropriate EHR. The third section will consist of Drs. Simon and Kashtan addressing the fears that practitioners have in dealing with EHRs, the realities of using them, and the benefits of that use, including future developments in EHR documentation functionality which have the potential for enhancing patient care, particularly with regard to patient portals.

SUMMARY OF THE ABPN MOC PROGRAM: LIFELONG LEARNING FOR PSYCHIATRISTS
Chair: Larry R Faulkner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) The factors that have resulted in the development of an ABPN MOC Program; 2) The specific requirements of the ABPN MOC Program; 3) Recommended strategies to fulfill MOC requirements and document MOC activities.

SUMMARY:
Consistent with the MOC Standards of the American Board of Medical Specialties, the American Board of Psychiatry and Neurology (ABPN) has developed an MOC Program consisting of four parts: Professionalism and Professional Standing; Lifelong Learning and Self-assessment; Assessment of Knowledge, Judgment, and Skill; and Improvement in Medical Practice. The major goal of MOC is to document that an ABPN diplomate has taken steps to maintain the competence required to provide quality patient care. The ABPN MOC requirements for Lifelong Learning and Self-assessment and Improvement in Medical Practice provide diplomates the opportunity to choose from a range of activities that best meets their needs, and the ABPN Physician Folio enables diplomates to attest to their completion of MOC activities. This presentation will review the rationale for and the specific requirements of the four parts of the ABPN MOC Program as well as demonstrate how to use the ABPN Folio to document MOC activities.

SEXUAL TRAFFICKING OF THE BLACK FEMALE: SURVIVING MODERN DAY SLAVERY
Chairs: Kimberly A. Gordon, M.D., Napoleon B. Higgins Jr., M.D.
Presenters: Richelle Long, Ph.D., Denese Shervington, M.D., M.P.H., Lauren A Teverbaugh, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To identify risk factors that increase vulnerabilities for African American children and youth to become victims of sex trafficking; 2) To understand the concept of normalized sexual harm and its impact on the desensitization of African-American youth; 3) To provide mental health clinicians with the tools to accurately identify, diagnose and treat the mental and physical health needs of women exploited by sexual trafficking; 4) To propose preventive based strategies that mental health clinicians may employ to aid in the anti-trafficking movement.

SUMMARY:
Modern human slavery, also known as human trafficking, is a global health concern. As declared by President Barack Obama, "[human trafficking] ought to concern every community, because it is a debasement of our common humanity. It ought to concern every community, because it tears at our social fabric. It ought to concern every nation, because it endangers public health and fuels violence and organized crime." In 2003 the Trafficking Victims Protection Act's (TVPA) focus was broadened to include domestic human trafficking bringing attention to the epidemic of injustice that destroys so many lives. According to the U.S. Department of State, human trafficking is an umbrella term for activities involved when someone obtains or holds a person in compelled service. Sex Trafficking and Child Sex Trafficking are two of the most devastating forms of enslavement that are captured by this brand of modern day slavery.

Per the Trafficking Victims Protection Act (TVPA), sex trafficking occurs when a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age. Sex trafficking has devastating consequences for minors, including long-lasting physical and psychological trauma, disease including HIV/AIDS, drug addiction, unintended pregnancy, malnutrition, social ostracism, and death. Sadly, of the confirmed sex trafficking victims in the United States whose race was known, 26 percent were white and 40 percent were black. This disparity is borne out by the risk factors for recruitment into trafficking: young age, poor education, history of abuse or violence, single parenting, desperate social economic circumstances and war circumstances. Notably, the foster care system unwittingly supplies a ready source of vulnerable at-risk youth. According to the National Center for Missing and Exploited Children, 60 percent of runaways who are victims of sex trafficking had been in the custody of social services or foster care. Essentially, the circumstances that lead minors into foster care are often what make them especially vulnerable to sex trafficking. Without an involved parent, the "pimp- recruiter" initially enters their life in the role of protector.

Studies demonstrate that victims of sexual trafficking have greater mental health needs and more severe trauma compared to victims of other crimes, and can be encountered in emergency departments, health clinics, family planning clinics and HIV/AIDS clinics. Human Trafficking indicators, or "red flags" include living with an employer, inability to speak to individual alone, scripted and rehearsed responses, submissive or fearful affect, and under 18 and in prostitution. Because mental health providers often provide the most intensive interview during a medical encounter, there is tremendous opportunity to identify, assist, and advocate for this vulnerable population.

SYSTEMS BASED PRACTICES: HOW DO WE TEACH THE FOUR FACTOR MODEL OF SBP
Chair: Stephanie LeMelle, M.D.
Presenters: Carisa Kymissis, M.D., Dianna Dragatsi, M.D., Jean-Marie Bradford, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will learn about the Four Factor Model of SBP, how the model was derived and how ACGME used the model to inform the national milestone requirements for SBP; 2) Participants will see how the Four Factor model can be used in supervision to teach SBP; 3) Participants will learn how to use the Four Factor Model of SBP as a tool for working through difficult clinical cases.

SUMMARY:
Behavioral health services are more often provided in community settings involving multiple systems of care. This can be referred to as Systems Based Practices (SBP). ACGME requires SBP as one of the core competencies for residency training. To conceptualize SBP for training purposes a factor analysis was done which revealed that SBP

in psychiatry can be defined as a set of roles performed by psychiatrists to meet the comprehensive needs of the patient within and beyond the healthcare system. The identified roles, Patient Care Advocate, Team Member, Information Integrator and Resource Manager, provide a conceptual framework for the four factor model of SBP that is measurable and observable and can be used to inform residency training in SBP. This workshop will focus on how this model was developed and is used as part of a larger public psychiatry, recovery oriented residency curriculum.

SEXUAL ORIENTATION, GENDER IDENTITY, AND SEX DEVELOPMENT COMPETENCIES IN MEDICAL EDUCATION: IMPLICATIONS FOR PUBLIC PSYCHIATRY

Chairs: Brian Hurley, M.B.A., M.D., Kristen Eckstrand, M.D., Ph.D.
Presenters: Tiffani St.Cloud, Petros Levounis, M.A., M.D., Kristen Eckstrand, M.D., Ph.D., Brian Hurley, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe how improving competency-based medical education on sexual orientation, gender identity, and sex development applies to the health needs of individuals who are LGBT and/or born with DSD; 2) Explain the importance of specifying competencies and educational milestones on sexual orientation, gender identity, and sex development in medical training.; 3) Generate potential opportunities to integrate teaching about sexual orientation, gender identity, and sex development in graduate medical training and clinical practice; 4) Discuss the relevance of institutional climate and faculty education to developing clinical competence with sexual orientation, gender identity, and sex development issues; 5) Examine the implications of the AAMC's competency-based medical education framework to the practice of community and public psychiatry.

SUMMARY:
Community and public psychiatrists provide treatment to a diverse set of patients, including lesbian, gay, bisexual, and transgender (LGBT) people and those born with differences of sex development (DSD). As a whole, these populations experience a greater degree of mood and anxiety disorders, suicide, trauma, and substance use as compared with the general population. The minority stress model describes specific stressors and coping mechanisms that significantly impact these mental health outcomes. Community and public psychiatrists play a valuable role in supporting the optimal mental health of these populations, however there is significant variability in the training received with respect to these patient populations. Educational strategies that optimize care for individuals who are LGBT and/or those born with DSD are therefore essential to the modern practice of community and public psychiatry.
Medicine has evolved in its conceptualization of individuals across the sex development, sexual orientation, and gender identity spectra over several decades. For example, the DSM has gone from initially classifying homosexuality as psychopathology and conflating gender identity with sexual orientation, to removing homosexuality as a disorder and refraining from pathologizing the identity of transgender individuals.
Competency-based medical education is an educational framework beginning in medical school to support effective learning for the development of knowledge, skills, attitudes, and behaviors necessary for clinical practice. Achieving and assessing competence extends into post-medical graduate education. The Association of American Medical Colleges (AAMC) created an advisory committee in 2012 to promote LGBT and DSD health through advancement of medical education on sexual orientation, gender identity, and sex development. The committee has developed competencies specific to these populations and mapped them to the pre-existing framework of competency-based medical education. Additionally, the committee has authored a publication that describes how to: (1) integrate these competencies into existing medical curricula; (2) promote the necessary institutional climate change across levels of experience, including faculty and administrators; and (3) assess the achievement of physician competence in these areas.
This workshop will provide an overview of the competency based education focused on sexual orientation, gender identity, and sex development, discuss its relevance to community psychiatry, and promote understanding of integration of the competencies into graduate medical training and enhancing institutional climate.

"BENDING" DIAGNOSTIC CRITERIA

Chairs: Donovan A. Wong, M.D., Joanna Fried, M.D., Wesley E. Sowers, M.D.
Presenters: Donovan A. Wong, M.D., Joanna Fried, M.D., Sosunmolu O. Shoyinka, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize how 'bending' diagnostic criteria is happening in current psychiatric practice.; 2) Understand the reasons for and against 'bending' diagnostic criteria.; 3) Discuss alternatives and come to a consensus on the practice of 'bending' diagnostic criteria.

SUMMARY:
"Bending" diagnostic criteria is an increasingly recognized, though still often unspoken, continuum of practices in psychiatry that poses many challenges to psychiatrists. Done for many reasons, including to help patients obtain social service resources, this practice has the potential to offer relatively immediate, tangible benefits for patients, practitioners and society, and there is a strong argument for this being appropriate care for some patients. However, there are also arguments against this practice that see it leading to long-term harm. Psychiatrists are generally left on their own to navigate the many competing pressures and complex ethical issues involved in the decisions regarding diagnosis, and with many different perspectives, this leads to inconsistent practice. This symposium will attempt to discuss and make explicit the different forms of and reasons for and against "bending" diagnostic criteria, in order to explore this practice further, consider alternatives and come to a consensus on the practice.

VANDERBILT BEHAVIORAL HEALTH POPULATION HEALTH STRATEGY: LESSONS LEARNED FROM AN INTEGRATED, ACADEMIC, STATE WIDE, HEALTHCARE DELIVERY SYSTEM

Chair: Harsh Trivedi, M.B.A., M.D.
Presenters: Theresa Herman, M.B.A., M.D., Jerry Halverson, M.D., Todd Peters, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand population health as a concept and how Vanderbilt Behavioral Health has applied it for its population; 2) Understand the role of quality measures, patient registries, and outcome measures in value based care; 3) Understand the role of electronic health records, health information exchanges, and meaningful use in healthcare reform; 4) Understand the role of the psychiatrist in such a system and how to best prepare for the future.

SUMMARY:
The Vanderbilt Health Affiliated Network comprises 30+ hospitals, 3,000 physicians, and over 2 million covered lives across Tennessee. Vanderbilt Behavioral Health is tasked with defining and implementing the enterprise wide population health strategy for Vanderbilt University Medical Center. This workshop will illustrate how the population health strategy was developed for behavioral health at Vanderbilt.
There will be a focus on the development of quality measures in psychiatry, the importance of patient registries, and the availability of reliable outcome measures for value based care. The role of such measures in determining reimbursement will be explored as well.
The will also be a focus on electronic health records, the development of healthcare information exchanges, and Vanderbilt's approach to concerns regarding confidentiality and integration.
Last, we will explore the role of psychiatrists in such a system and discuss how to prepare for such roles in the future.

WILL GENETICS + ENVIRONMENT = A NEW PSYCHIATRY?
Chair: Hunter L. McQuistion, M.D.
Presenters: Frances Champagne, Charles Marmar, M.D., Ezra Susser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how epigenetic research is beginning to illuminate our understanding of interaction between environment and biology ; 2) Understand how genetic research is illuminating understanding of interaction between environment and biology; 3) Consider the potential implications for human behavior, clinical practice, and the broad social milleu.

SUMMARY:
With the emergence of personalized medicine, genetic research is offering the prospect to affect dramatically the diagnosis and treatment of disease. In psychiatry, understanding the role of the gene is nascent, but highly evocative in its power, particularly considering how the genome, and our progressive understanding of its plasticity, is an arbiter of human vulnerability and resiliency to mental illnesses. In addition to the influence of patently biological genotypic mediators, the role of social and interpersonal stress is beginning to be revealed as affecting phenotype, bringing enhanced meaning to the concept of social determinants of disease.
This session will explore the effect of genetic and epigenetic research on our
understanding of how the environment affects biology and psyche from womb to grave. Presenters will describe basic and clinical research examining this interplay and lead in a discussion with workshop participants of how the potential culmination of this understanding could affect clinical practice, public health initiatives, and social policy.

SPEED UP? TIME PRESSURE IN THE LIVES OF OUR PATIENTS AND OURSELVES
Chairs: Kenneth S. Thompson, M.D., John Santopietro, M.B.
Presenters: Kenneth S. Thompson, M.D., John Santopietro, M.B.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) appreciate the dynamics of the perception of "speed up" on the lives of people with a focus on the role of economic demands and technology; 2) understand the time pressures on psychiatric practice and its impact on working conditions and outcomes; 3) consider strategies that psychiatrists can utilize to create "more time" for their patients, their practices and their own lives.

SUMMARY:
The pressure of time and the sense that there is less and less of it available is pervasive in our society, in the lives of many of our patients, in practice itself and in our own lives. This session will first trace the impact of the perceived speed-up and explore some of the notions behind these perceptions. Is technology speeding us up? Is it the economy? Is it our shifting cultural values? The focus will then shift to considering the impact on psychiatric practice as symbolized in the infamous "15 minute med check". Particular attention will be paid to notions about how to lessen the pressure of time in the lives of our patients, in our practices and in our selves. With the work speeding up, with the pace of change itself speeding up, how do we fight to protect 'clinical soul' and is it our place to do so? What happens if we don't? Is there a place in our work for the equivalent of 'slow food' of 'farm to table' psychiatry and what would that look like? Should we be defenders of 'reflective space' and internality? If not us, then who?

CHALLENGES AND INNOVATIONS IN RURAL PSYCHIATRY
Chairs: Manish Sapra, M.D., Penelope Chapman, M.D.
Presenters: Kenneth Nash, M.D., James Schuster, M.B.A., M.D., Penelope Chapman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) recognize strengths and limitations of rural communities; 2) identify challenges of delivering mental health care in rural communities and learn about clinical programs that address these challenges; 3) Learn how a unique partnership between state , academic and clinical agencies is working to improve mental health care in rural regions; 4) Understand how to plan and execute clinical programs in rural communities .

SUMMARY:

Delivering quality mental health care in rural areas can be both challenging and a rewarding experience. A new Fellowship program at the Center of Excellence in Rural Public Psychiatry at University of Pittsburgh has implemented a training program for early career psychiatrists. The program for these psychiatrists includes an extensive didactic program and experiences in a variety of innovative programs. The purpose of this symposium is to introduce participants to several programs that are available to fellows that address challenges of access and quality improvement. After a brief overview of the fellowship program, presentations will focus on how these projects were conceived, designed, and implemented, with lessons learned from successes and failures. The following discussion will focus on identifying and overcoming challenges in rural areas. This discussion will encourage audience members to bring forward ideas or projects in development.

PUBLIC HEALTH IMPACT OF MARIJUANA LEGALIZATION
Chair: Leslie Marino, M.D., M.P.H.
Presenters: Gregory Tau, Mark A.R. Kleiman, Ph.D., Kevin P. Hill, M.D., M.H.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the health effects of marijuana, with special attention to the effects on the developing brain; 2) Discuss the impact of marijuana legalization on health and health service utilization.; 3) Describe various policy and regulation initiatives that can be implemented at the state level to limit the negative health impacts of marijuana legalization.

SUMMARY:
The prevalence of marijuana use in the United States is on the rise, particularly among youth. Data from the National Survey on Drug Use and Health show that 12.6% of persons ages 12 and over used marijuana in the past year, and rates among young people are particularly high.1 In addition, there is a growing body of evidence that marijuana use in young adults has significant harmful effects on the developing brain of adolescents.2 Adolescents are a particularly vulnerable group given that research shows that early onset use of marijuana results in an elevated risk of marijuana dependence.3 As legalization of marijuana is being realized in Colorado and Washington, researchers are attempting to track the impact of legalization on mental health and overall health so that other states and policymakers may benefit from "lessons learned" given the reality is that marijuana legalization is likely to gain in support among other states. In order to limit the potentially negative consequences of marijuana legalization, policymakers can learn from tobacco and alcohol in order to create regulations that protect the public well-being.4 The aim of this workshop is to review data on the effects of marijuana on the brain and mental health and to discuss examples of how legalization in Colorado and Washington has impacted health and health services utilization in these states. Furthermore, potential policy reforms will be discussed as a way to limit the negative health impacts of marijuana use.

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3.Chen CY, Storr CL, Anthony JC. Early-onset drug use and risk for drug dependence problems. Addict Behav 2009;34:319-22.
4.Pacula RL, Kilmer B, Wagenaar AC, Chaloupka FJ, Caulkins JP. Developing public health regulations for marijuana: Lessons from alcohol and tobacco. AJPH 2014; 6:1021-1027.

LESSONS FROM FERGUSON: THE ROLE OF PSYCHIATRISTS IN CARING FOR TRAUMATIZED MINORITY COMMUNITIES
Chair: Uchenna Achebe, M.D.
Presenters: Kimberly A. Gordon, M.D., Altha Stewart, M.D., Napoleon B. Higgins Jr., M.D., Danielle R Hairston, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) recognize the damaging effects of violence on marginalized communities when exposed to increasingly violent interactions with law enforcement. ; 2)

identify community resources which can be useful in the aftermath of such trauma; 3) develop a comprehensive community intervention program which can be implemented on a fairly large scale for managing the psychiatric sequelae of such trauma among minority communities; 4) identify cultural norms that foster social exclusion (marginalization) of minority groups and facilitate re-victimization of communities.

SUMMARY:
The recent extra-judicial killings of Eric Gardner in New York, Michael Brown in Missouri, Ezell Ford in California as well as the now-nearly-forgotten shootings of Sean Bell and Amadou Diallo by men of New York's Finest has resulted in growing concern about the use of disproportionate and deadly force by law enforcement against young men of color. All the above victims were unarmed and, in at least one instance, one of the victims had a well-documented and widely known history of mental illness. The killing of young men of color is not by any means new. In fact the rates of homicide perpetrated by minorities against minorities referred to as "black on black crime" is often times the highlight of media news reports. According to the CDC, the death rate due to law enforcement actions for African-Americans was three times what it was for Whites from 1999 to 2011(1) . Also, the US Civil Rights Commission, an independent, bipartisan agency established by Congress has noted that "reports of alleged police brutality, harassment, and misconduct continue to spread throughout the country. People of color, women, and the poor are groups of Americans that seem to bear the brunt of the abuse....." (2). Events such as Ferguson killing only serves to highlight what seems to be a widely-recognized trend of abuse of power and further marginalizes this "endangered" demographic. The simple act of "walking while black" has now effectively become a capital offense. As community psychiatrists who may be or are already involved in the treatment of traumatized families and communities following each of these killings, we need not only to recognize the depth of the trauma but also be able to identify and effectively utilize community resources which can aid in treatment of these individuals and/or communities. Finally, we need to develop evidence-based intervention programs that is both culturally sensitive and trauma informed which can be implemented on a large-scale in communities subjected to mass trauma.

PSYCHIATRISTS AND PHYSICIAN ASSISTANTS: COLLABORATING TO EXPAND ACCESS
Chair: Ellen Rathfon
Presenters: James Cannon, Hsiang Huang, Jeffrey Katz, Juliane Liberus

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Effective psychiatrist and PA collaboration expanding outpatient psychiatric services in an urban public safety net health system; 2) Psychiatrist-PA collaboration in a hospital inpatient psychiatric unit; 3) Challenges identified and overcome in establishing effective psychiatrist-PA integration; 4) How a PA in a rural community where there is no psychiatrist addresses the mental health needs of his patients.

SUMMARY:
The current and projected shortages of psychiatrists to meet expected patient needs is well documented and well known. Less understood is the ability of physician assistants (PAs) to collaborate with psychiatrists to expand access and help to meet demand in every setting. In this workshop, collaborating PAs and psychiatrists will share their first-hand experiences in expanding access to psychiatric services in urban outpatient and rural inpatient settings. The panel also includes a primary care PA from a rural North Carolina community with no psychiatrists, who will address challenges and solutions in his practice setting.

OCTOBER 10, 2015

RISKY CONNECTIONS: LAW, LIABILITY, AND THE PSYCHIATRIST ONLINE
Chair: John S. Rozel, M.D.
Presenters: Lara Chepenik, M.D., Ph.D., Michael J. Sacopulos, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify opportunities and risks of using clinical and nonclinical databases to guide patient care; 2) Identify opportunities and risks of having a professional or personal social media presence ; 3) Understand potential security concerns for mental health professionals from publically available information; 4) Apply basic open source intelligence techniques to enhance contextual understanding of specific cases; 5) Consider factors relating to online behavior of patients such as threats, self-reported behavior, and issues of ambiguous information.

SUMMARY:
Since inception, the internet has provided capacity for near-complete anonymity contrasted with incredibly intimate and detailed collections of personal information either accumulated by data mining systems or willingly shared through social media. Each extreme â€" and the clinical territory in between â€" creates a set of risks and opportunities for the connected psychiatrist. From the mandates of Meaningful Use, to the peril of HIPAA breaches, to the use and misuse of clinical data such as controlled substance prescription registries, to the complexities of personal and professional presence in social media, the modern psychiatrist must be aware of the risks and opportunities of connected care.
This workshop will help participants develop an understanding of the opportunities, for both patient and psychiatrist, provided by modern information technology to enhance clinical care and to mitigate associated risks.

PRACTICAL GUIDE TO PREPARING PSYCHIATRISTS TO PRACTICE IN INTEGRATED PRIMARY CARE AND MENTAL HEALTH SETTINGS
Chairs: Rachel Robitz, M.D., Steve Koh, M.D., M.P.H.
Presenters: Aniyizhai Annamalai, M.D., Jessica Thackaberry, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the benefits of training psychiatrists to function in integrated medical and psychiatric care outpatient settings.; 2) Compare a traditional psychiatric training setting to one which uses an integrated approach.; 3) Demonstrate a technique to train psychiatrists to function within an integrated medical and psychiatric care outpatient setting. .

SUMMARY:
The Patient Protection and Affordable Care Act (ACA) is both encouraging the development of and providing funding for patient centered medical homes (PCMH). At this time millions of Americans receive healthcare through PCMHs (1) and it is clear that the healthcare system is shifting towards providing physical and mental health services within an integrated setting (2). It is now a well-established fact that patients with serious mental illness (SMI) have a reduced life span of 20-25 years compared with the general population. This is largely attributable to medical co-morbidity. For many patients with SMI, the mental health center is the only point of contact with the healthcare system.
While collaborative care models have greater efficacy in treating some mental health conditions such as depression in primary care settings (3), the evidence for collaborative care within mental health settings is still in its infancy; however, psychiatrists are being called upon to work within these systems and take on a more active role on overseeing medical care for the SMI population. They often need to be primarily responsible for coordinating care, collaborating with primary care providers and providing on-site preventive care.
Some curricula have been described on training psychiatric residents to function as collaborators and consultants within primary care settings (4). However, there is a lack of published curricula on training psychiatrists to function as leaders of healthcare teams in mental health settings. This workshop aims to provide practical guidance on how to train psychiatrists in this emerging setting.
The practical guidance provided through this workshop will be demonstrated in a multimedia and interactive format for those interested in educating psychiatrists to provide care in integrated and collaborative settings. Participants will work through a case presented by video in both a traditional manner and then using an integrated approach. By comparing the two approaches through interactive discussion, participants will begin to develop an optimal approach to deliver integrated medical and psychiatric care to SMI patients. The workshop will highlight mechanisms to streamline this care within the constraints of current practice settings.

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2.Working Party Group on Integr Behavioral Healthcare. The development of joint principles: integrating behavioral health care into the PCMH. Ann Fam Med, 2014; 12(2): 184-5.
3.Colton CW, et al. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis, 2006; 3(2): A42
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INTEGRATING NEWLY GRADUATED ADVANCED PRACTICE NURSES INTO COMMUNITY SETTINGS: A STRATEGY FOR RECRUITMENT, RETENTION AND IMPROVED CLINICAL PERFORMANCE
Chair: Patrick S. Runnels, M.D.
Presenters: Katherine Proehl, D.N.P., Maureen Sweeney, M.S.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify key components of an integrated community psychiatry clinic setting that enhance and detract from establishing and maintaining healthy advanced practice nursing culture; 2) Recognize strengths and learning needs of newly graduated psychiatric NPs in community psychiatry settings; 3) Discuss training strategies for newly graduated psychiatric NPs that successfully bridge the knowledge/experience gap which currently exists between graduate school and practice; 4) Identify strengths and barriers to the development of a sustainable, healthy APN practice in individual clinic setting ; 5) Explore the role that psychiatrists can play in supporting these programs.

SUMMARY:
Advanced practice nurses are well suited to work in community mental health settings where teamwork and patient-centered care are highly valued. Moreover, they are a key part of the strategy to address impending psychiatric workforce shortages and continue to be strongly recruited by community mental health agencies. Despite these two aligned forces, recruitment and retention of advanced practice nurses remains a struggle for many community mental health agencies. This presentation will highlight one successful, nursing led model for integrating newly graduated psychiatric nurse practitioners into a community mental health agency. The success of the program has lead to expansion from just one agency to multiple agencies throughout the county over the past three years, with all seven participants continuing to serve within the system to date. This presentation highlights lessons learned and ongoing challenges in relation to the increasing demand for advanced practice nursing care in community settings.

CLIMBING THE LADDER OF SUCCESS: HOW SOCIAL STATUS, CLASS, AND INEQUALITIES INFLUENCE MENTAL HEALTH
Chair: Ruth S. Shim, M.D., M.P.H.
Presenters: Elizabeth Walker, M.P.H., Ph.D., Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define "subjective social status" and "social capital"; 2) Distinguish between objective and subjective measures of status and class; 3) Examine the connection between mental health disparities and social status.

SUMMARY:
As the inequality gap widens between the rich and the poor, individuals with serious mental illnesses often experience lower societal standing because of poverty, stigma, and/or societal exclusion. This workshop closely examines the concept of social status, and how individuals with serious mental illnesses perceive their own status in society. Previous research has suggested that subjective social status may predict declines in health status, and may do so more accurately than objective socioeconomic status measures (e.g., income, education, or occupation). Common self-report measures of class and status, including the "community" and "socioeconomic status" ladders will be discussed. We will review the evidence of how social status and class impact physical and

mental health outcomes, and we will examine qualitative data that captures personal narratives of social status and class in individuals with chronic comorbid physical and mental health conditions. This workshop will incorporate an interactive discussion format, in which participants will discuss clinical practice-based solutions to improve mental health through status-promoting interventions, including building social capital and advocating for social inclusion.

CULTURAL ASPECTS OF DOMESTIC VIOLENCE
Chair: Gail E. Robinson, M.D.

SUMMARY:
Domestic violence (DV) includes a combination of physical, sexual, and psychological abuse, threats, harassment, intimidation, and property damage. Consequences include: hopelessness; helplessness; depression; PTSD; substance abuse; suicide; physical injury; and death. While under-reporting is rampant, the National Violence Against Women Survey (NVAW) estimated that 22.l% of women and 7.4 % of men in the United States have been physically abused by an intimate partner in their lifetime. Women make up 85% of the victims of DV. DV against African American women is rarely covered unless it is sensational or unusual. Yet domestic violence is one of the leading causes of death for Black women. There is also a myth that violence is minimal in LGBT couples. The NVAW reports that 21.5% of men and 35.4 % of women living with a same-sex partner experience intimate-partner physical violence in their lifetimes. This workshop will provide an overview of the causes and consequences of DV with particular attention to issues faced by young African American women. As well, it will report on working with LGBTQ and HIV-affected survivors of DV, barriers to shelter and supportive services, and tools for providers to better meet the needs of LGBTQ and HIV-affected survivors of DV.

A JOURNEY FROM HUMILIATION TO RECOVERY: RESILIENCE IN MEDICAL EDUCATION
Chairs: Brittany Strawn, M.D., Christopher White, M.D.
Presenters: Eindra Khin Khin, M.D., Marsha W. Snyder, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define burnout, humiliation and resilience. Identify the prevalence of burnout in medicine.; ; 2) Reflect upon experiences of trauma and humiliation in the medical training experience and common physician characteristics that predispose to burnout.; 3) Understand the negative ramifications of burnout on patients, organizations and healthcare providers.; 4) Understand ways in which an individual can increase their resilience, and understand ways in which organizations can implement resilience training for healthcare providers.; ; 5) Be aware of models of implementing resilience training in medical education. Understand challenges to implementing resilience training and ways of overcoming these individually and organizationally.

SUMMARY:
Burnout is a nearly ubiquitous aspect of becoming a physician. The trainee is immured by medical culture, risking development of burnout while subjected to training tactics too often including humiliation, fear, and dehumanization - recapitulations of the trainers' own traumatic experiences in the field. Evidence demonstrates that burnout not only damages the clinicians' wellbeing and their surrounding interpersonal environs, but also adversely impacts patient care. Burnout and its repercussions are, at the core, emotional processes requiring recovery for the clinician to realize their full potential.
Resilience is a tool for managing and preventing burnout, thus allowing fulfillment of the clinicians' recovery needs, but definitive ways to inculcate medical students and residents with resilience are lacking. Dr. Ungar of the Resilience Research Centre defines that "in the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in a culturally meaningful way." Resilience is a fundamental aspect of the Recovery Movement, and while physicians strive to engender this quality in patients, they seldom see personal recovery or resilience as professional aims. As medical professionals, we must develop an individual capacity to navigate adversity and develop a work environment where both our recovery and that of our patients is respected.

This workshop will explore the following powerful questions: How can we discontinue the cycle of trauma in medical education? How do we, as trainees and physicians, recover from traumatization caused by the educational tactics of our medical community? And how do we train those following in our footsteps to be resilient? In addressing these questions, our panel of professionals experienced in teaching recovery and resilience will discuss ways in which individuals can develop their resilience and how institutions may support them, exploring methods of overcoming personal and institutional barriers to implementing resilience training. We feature speakers who have successfully implemented resilience-enhancing resident/medical student programs or who teach resilience training for residents.

Speakers include Dr. Marsha Snyder, an expert in physician wellbeing, founder and Medical Director for the Center for Physician Success and Wellbeing and author of the newly published textbook on physicians' health entitled, "Positive Health: Flourishing Lives, Well-Being in Doctors," Dr. Eindra Khin Khin, Assistant Professor of Psychiatry and Behavioral Sciences at George Washington University and developer of their Psychiatry Resident Wellness Program, and Dr. Miko Rose of the Michigan State University College of Osteopathic Medicine and founder of the Joy Initiative.

FROM MODEL PROGRAM TO THE REAL WORLD: PARACHUTE NYC'S TRANSITION FROM GRANT FUNDING TO SUSTAINABILITY
Chair: David C. Lindy, M.D.

Presenters: Neil Pessin, Ph.D., James E. Mills, L.C.S.W., Deirdre DeLeo, L.C.S.W., M.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand the issues involved in finding ongoing funding for a grant funded model program.; 2) understand the issues involved in shiftng the grant funded clinical model to a model that remains faithful to the original model while meeting new requirements of managed care funders. ; 3) understand the issues involved in helping clinical staff make the transition from grant funded to managed care. .

SUMMARY:
Advances in clinical care in community psychiatry often grow out of a dialectic between idealistically oriented model programs and the bottom line driven need for cost effectiveness. Examples of programs resulting from this tension include Assertive Community Treatment (ACT), intensive case management, and mobile crisis teams. Parachute NYC is a recovery oriented, model program designed to stabilize and treat people with psychosis using home-based, family oriented network meetings. It was funded by a 3 year federal grant awarded to New York City; its clinical component was piloted by the Visiting Nurse Service of New York (VNSNY). The grant created generous conditions in which we could learn to implement Parachute's complicated model and make it work on a daily basis. With the grant's end in June, 2015, we actively engaged in the process of achieving financial sustainability for Parachute. The model is designed to reduce cost by empowering clients and families and preventing emergency room and hospital use, and initial outcomes were consistent with these goals. Since New York State Medicaid Redesign relies heavily on Medicaid managed care, we attempted to interest managed care companies in Parachute as a cost effective model for treating psychotic clients in the community. This workshop will present our experience with this process. We will invite participation from the audience to share their experiences in achieving sustainability for clinically innovative programs.

PHYSICIAN PRESCRIBING DURING GROUP THERAPY, ADDICTION TREATMENT GROUPS, AND PSYCHOEDUCATION GROUPS
Chairs: Benjamin Crocker, M.D., Wesley E. Sowers, M.D.
Presenters: Jeffrey C. Eisen, M.B.A., M.D., Leah K. Bauer, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Plan successful start-up of group sessions that include medication prescribing in general mental health specialty settings, substance abuse and dual diagnosis programs, and in primary care integration; 2) Combine group, individual and care management

encounters to individualize treatment plan while optimizing access to services; 3) Use E&M coding, payor contracting and other tactics to make group prescribing financially viable; 4) Use treatment groups for training and team building in organized systems of care; 5) Advocate for groups as an avenue for consistent treatment relationships in a time of great staffing turnover.

SUMMARY:
Physician led group treatment is a tradition going back to the days of Moral Treatment, renewed in the crucible of WWII and in the flowering the age of physician psychotherapy that followed it, and the subsequent community mental health movement. Now as team based treatment is reinvented in ACO's and in integration of behavioral health into general healthcare, treatment groups in which physicians and other behavioral health clinicians provide psychotherapy, psychoeducation and medication prescribing simultaneously can increase access to care, improve teamwork and ongoing training of staff while also improving efficiency in use of scarce staffing resources while maintaining direct physician participation and oversight of care.

Our symposium will describe in detail the development, refinement, successes and tribulations of starting and maintaining comprehensive psychiatric treatment in groups in a number of different settings. In the process of this we will address the capacity of group experience to address issues of power, conflict about treatments and treatment goals, and institutional dynamics regarding dependency issues in treatment, especially involving reinforcing psychotropic medications. We will relate this to issues in the integration of the cultures of traditional psychiatric practice and chemical dependency services.

SECOND-GENERATION ASIAN-AMERICANS IN THE INPATIENT SETTING
Chairs: Priti Ojha, M.D., Justin Kei, M.D.
Presenters: Steve Koh, M.D., M.P.H., Jessica Thackaberry, M.D., Haoyu Lee, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review background of mental illness in second-generation Asian-Americans; 2) Review family dynamics and cultural influences on psychiatric care; 3) Overview of cultural competency issues in working with Asian-American patients and families; 4) Identify obstacles to care when treating second-generation Asian-American patients in the inpatient setting; 5) Identify resources and provide guidance on how best to implement and utilize available resources.

SUMMARY:
Second-generation Asian-Americans now make up nearly a third of the Asian population in the United States. These are Asian-Americans who are born in the United States and often have conflicting cultural norms that straddle that of their first generation immigrant parents and their American environmental norm. This a unique population that needs special attention. For instance, young Asian American women have been noted to have a higher rate of suicide than other ethnicities in that age group. Additionally, Asian American groups do not tend to seek out community resources outside of their immediate cultural access points. Further, according to the CAPES study, only a fraction of Asian-Americans experiencing psychiatric symptoms seek care. Their access to care is largely limited by cultural values and the associated stigma of mental illness. One of the greatest barriers to care of second generation Asian-Americans in the inpatient setting is rallying support from family. Oftentimes patients in this subpopulation are reluctant to include their families in their care plan due to the limited acceptance of mental illness as a disease process. Another complication arises when it is the parent who is often involuntarily admitted to psychiatric unit. In these instances, often there exists a friction between parents, children, and the care provider team. Though research in this population is rather limited, clinical outcomes in general have been noted to be better when families are included in the treatment. The involvement of the family is especially important for continued care after discharge and continued progress in their mental health recovery. The purpose of this symposium would be to:
- Review background of mental illness in second-generation Asian-Americans
- Review family dynamics and cultural influences on psychiatric care
- Overview of cultural competency issues in working with Asian-American patients and families

- Identify obstacles to care when treating second-generation Asian-American patients in the inpatient setting
- Identify resources and provide guidance on how best to implement and utilize available resources
References:

Brice, Chad, et al. "Social Anxiety and Mental Health Service Use Among Asian American High School Students." Child Psychiatry & Human Development (2014): 1-9.
Nation's Foreign-Born Population Nears 37 Million". Press Release. U.S. Census Bureau. 31 January 2012.
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Monthly Vital Statistics Report. Center for Disease Control and Prevention/national Center for Health Statistics; Vol. 46. No. 1. August 17, 1997.
Huang, Gary. "Beyond Culture: Communicating with Asian American Children and Families. ERIC/CUE Digest Number 94." (1993).Communicating with Asian American Children and Families. ERIC/CUE Digest Number 94.

THE GUN TALK: HOW TO TALK TO PATIENTS AND FAMILIES ABOUT GUNS AND GUN SAFETY
Chair: John S. Rozel, M.D.
Presenters: Layla Soliman, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the legal context and public health impact of firearm access in the United States; 2) Understand and use basic vocabulary, categories, and concepts relating to firearms and ammunition; 3) Effectively assess access to firearms, storage and handling habits including exploring guns and violence risk; 4) Apply effective -- and avoid ineffective -- techniques for counseling about gun safety using motivational interviewing and cross cultural models; 5) Consider effective, risk conscious, approaches to documentation of discussions with patients and families about firearms .

SUMMARY:
How do you ask about access to guns? How do you counsel about gun safety? How do you engage patients and families who do not want to talk openly about gun issues? Cutting through the media and political rhetoric to deliver a clinically effective and evidence based intervention can be daunting. Some states have even passed laws to intimidate or punish physicians who ask about firearms. Adding to this challenge, discussing firearms may amount to cross-cultural work without the psychiatrist even being aware that there is a cultural divide impacting the quality of their assessment and the impact of their intervention. Nonetheless, assessing, documenting and counseling about access to firearms is a vital clinical skill for psychiatrists and there is surprisingly little guidance available on effective strategies and tactics.
Adapting lessons from cross-cultural psychiatry and motivational interviewing, this workshop will help professionals better understand firearms, culture, public health and policy and the pragmatics of effectively asking and talking about firearms with consumers and their families. Special attention will be paid to the legal and cultural factors that make firearm access uniquely ubiquitous in the United States and fundamental concepts and terminology for the firearms novitiate. Detailed and scalable interview approaches to identify access, use, and storage of firearms will be explored. Specific questioning strategies for higher risk patients will also be offered. Effective interventions modeled on motivational interviewing can be used to navigate discussions about gun security and access in ways to minimize the risk of alienating patients or their families.

WHAT'S IN A NAME? IS IT TIME TO RETIRE THE TERM "COMMUNITY PSYCHIATRY?"
Chair: Michael A. Flaum, M.D.
Presenters: Wesley E. Sowers, M.D., Michael A. Flaum, M.D., Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss what is meant by the term 'community psychiatry' in terms of core skills and activities; 2) Describe how the core skills and activities of a 'community psychiatrist' differ from those of a 'general' psychiatrist; 3) Discuss the potential importance of 'branding' and 'messaging' in affecting policy, attitudes and training in psychiatry. .

SUMMARY:
This workshop will debate the issues of whether and why it may be important to actively retire the term "community" psychiatry, perhaps replacing it with something else.

Drs. Sowers will present and discuss a current definition of community psychiatry as follows: Community Psychiatry is a branch of psychiatry in which psychiatrists employ person-centered and recovery-oriented practices in clinical care. It emphasizes prevention of illness and the importance of creating healthy environments. It strives to create a political will to provide security and respect for all members of the community. Community Psychiatrists facilitate collaboration and provide leadership for the creation of comprehensive and fully integrated services for all members of society, but particularly for those members who have greatest need.

Dr. Flaum will argue that; 1) while the above definition does a nice job of integrating the historical core concepts of community psychiatry with some key contemporary elements, the term "community psychiatry" remains poorly understood at almost all levels; 2) that the centrality of the term "community" made more sense a half century ago when we were in the midst of the paradigm shift of caring for the most seriously mentally ill within their communities rather than in segregated institutional settings; 3) that branding the above definition as the subspecialty of "community" psychiatry may be marginalizing what should be the core skills, activities and goals of the field of psychiatry as a whole; and therefore: 4) that rather than defining a subspecialty within psychiatry, the above definition might more appropriately be applied to field of psychiatry as a whole, (perhaps called "general psychiatry") with everything else being a subspecialty.

Dr. Thompson will discuss the potential importance and impact that branding and messaging may have on influencing policy, training and practice, using the example of the work done in family medicine over the past 20 years in their "Future of Family Medicine Project".

AN INTERDISCIPLINARY PERSPECTIVE ON MINORITY MENTAL HEALTH
Chair: Vanessa Torres-Llenza, M.D.
Presenters: Maria Espinola, Psy.D., Vanessa Torres-Llenza, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Explore the advantages of collaborative work between psychiatrists and psychologists and discuss ways to overcome the challenges associated with coordinating care; 2) Examine the use of the of the DSM-V Cultural Formulation Interview by professionals from the fields of psychiatry and psychology; 3) Discuss the relevance of ethnopsychopharmacology in the efforts to reduce mental health care disparities.

SUMMARY:
The purpose of this workshop is to highlight the importance of collaboration between psychiatrists and psychologists to improve patient's outcomes and reduce the mental health care disparities that affect ethnic and racial minorities. Workshop presenters will speak about the advantages of interdisciplinary work and the challenges often associated with coordinating care. In order to provide examples of collaboration, presenters will offer an overview of the use of the DSM-V Cultural Formulation Interview by professionals from the fields of psychiatry and psychology. The case studies of an immigrant Latina adult woman and an African American adolescent male will be utilized to discuss the relevance of the Cultural Formulation Interview's 16 questions and 12 supplementary modules. Additionally, presenters will discuss the importance of taking into account ethnopsychopharmacology issues when gathering medical information from patients, when prescribing medications, and when communicating with other providers. Participants will be invited to share their experiences of collaborating with professionals from the fields of psychology and/or psychiatry. They will also be provided with the opportunity to ask questions about ethnopsychopharmacology concepts and the use of the DSM-5 Cultural Formulation Interview.

PERFORMANCE MEASURES IN PSYCHIATRIC PRACTICE: AN UPDATE FOR PSYCHIATRISTS ON PAYMENT REFORM
Chair: Jerry Halverson, M.D.

Presenters: Jack Mcintyre M.D., M.D., Michael M. Miller, M.D., Harsh Trivedi, M.B.A., M.D., Jerry Halverson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) demonstrate awareness of transition from to fee for service to pay for value; 2) define what a performance measure is; 3) identify examples of performance measures in psychiatric practice.

SUMMARY:
Healthcare reform has hastened changes in how providers of mental health and general medical services are paid for their professional work. Even before the adoption of the Affordable Care Act there was a movement towards "paying for value" in which providers are paid based on outcomes on certain measures rather than how many procedures or units of service are completed by the provider. These changes will affect every psychiatric practice, especially in cases where payments will be "bundled"-with hospital charges and all charges by all clinicians on the case being rendered in a lump sum, with it left up to the providers to determine "who gets what slice of the pie." This workshop will help practicing mental health professionals become more aware of changes in payment systems that are emerging so that they will be able to adjust their practice styles as necessary. The workshop will begin with a review of evolving methods of payment for services and what they will mean for payment for psychiatric services, including within Accountable Care Organizations (ACOs). The presenters will then discuss performance measures in medicine, psychiatry, and addiction medicine, and how these are aligned with practice guidelines, "best practices," and quality improvement. Finally, there will be time for discussion of payment reform and linkages between practice guideline adherence and payment for services

CHANGE DYNAMICS AND SURVIVAL STRATEGIES IN A RAPIDLY EVOLVING PROFESSIONAL WORLD
Presenter: Mary Helen Davis, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List major changes to the profession, healthcare delivery system and regulatory world in the last decade; 2) Understand the impact and potential impact upon the individual and system in which they work; 3) Develop your own personal skill set for change management and resiliency in the face of change.

SUMMARY:
The past decade has seen rapid information acquisition that has resulted in complex changes in concepts of professionalism, the delivery of healthcare, medical education ,with changes in private and academic environments accompanied by shifts in medical regulation and public policy. Understanding the dynamics of change in rapidly evolving systems is not a skill set taught in medical school. The complexities brought about by the rate of information acceleration can become professionally disorienting. Rapid scientific and technological advances can threaten the harmony of a profession. This workshop will explore these changes, trends, promises and threats in healthcare, from workforce issues, increased regulation, to toxicity in the workplace. While change can represent a time for opportunity, dealing with uncertainty also poses risk for unintended consequences. These issues will be described and explored as well as providing a discussion on strategies to manage, adapt and enhance resiliency in both individuals, programs and systems of care.

BEYOND THE LAUNCHING PAD: A FORUM FOR PLANNING FOR LIFE AFTER RESIDENCY
Chair: Stephen M. Goldfinger, M.D.
Presenters: Marshall Forstein, M.D., Ellen Haller, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) have a clearer idea of how proceed with their careers after residency; 2) be able to describe the fellowship application process; 3) demonstrate the ability to discuss practice and job options.

SUMMARY:

The workshop organizers, who among them have decades of experience advising senior residents on issues of career trajectories, lifestyle choices, and post-graduation decisions are offering this workshop as a "consumer-driven" place to bring your questions about life after residency. Although essentially or residency training programs provide thoughtful and well-designed didactics and clinical supervision, we have found that residents around the country consistently struggle with issues- and the lack of information- about what to do after residency is over.

The sorts of topics that we hope you will bring for discussion include:

-Is doing a fellowship essential? How about if I want a career in academia?

-Does taking a non-accredited fellowship make sense?

-When should I start looking for jobs? Is it like interviewing for residency? -What should I be asking about besides salary and hours?

-Should I change towns, or stay where I trained? Why?

-Everyone keeps warning me the entire healthcare system is changing. How do I prepare for that?

-How does one set up a private practice? Should I look for salaried or self-employed positions?

-Does anyone do psychoanalysis anymore?

-Can I have an academic career and still earn a decent living?

-I want to be a ??????.... How do I get there?

-I'm on a J-1 visa. What are my options?

These are, of course, not meant to be a comprehensive list, but are the kinds of questions we'd be happy to (help) answer!!

TRANSITIONS IN CARE BETWEEN OUTPATIENT, EMERGENCY, AND INPATIENT SETTINGS: A CASE STUDY FROM BELLEVUE HOSPITAL
Chair: Joshua Berezin, M.D., M.S.
Presenters: Mary Anne Badaracco, M.D., Amit Rajparia, M.D., Rebecca Capasso, M.D., Amy S. Hoffman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify challenges associated with transitions in care between the outpatient, emergency, and inpatient settings; 2) Recognize potential improvements within systems that could directly or indirectly increase efficiency and quality of care during transitions between settings ; 3) Propose system and policy level changes that would improve coordination of care between different settings.

SUMMARY:
Transitions between outpatient and inpatient settings are fraught with inefficiencies and missed opportunities. In emergency settings, patients often present in crisis precisely because they lack outpatient care. Other patients rely heavily on emergency services and hospitals, but their care is fractured among various institutions. In both cases, the lack of information leads to time-intensive detective work or reflexive admissions. Heavy consumers of emergency services can have hundreds of visits, creating an information overload that obscures rather than clarifies the clinical picture. Patients themselves are often unable to provide meaningful histories because of acute symptoms, intoxication, or seeking secondary gain. These issues lend themselves to redundancy, inefficient use of resources, unnecessary and costly admissions, medication errors, and burnout. Disposition from the emergency room creates a transition either back to the community or to an inpatient unit. Discharge to the community is hampered by difficulty contacting providers, a limited ability to make psychosocial interventions that address underlying issues, and the need to refer to walk-in clinics. These limitations place the onus of navigating complex systems of care directly onto patients. Those who are admitted to the hospital should theoretically have smoother transitions, but inevitable errors and mistakes are often propagated rather than corrected. The trend towards shorter length of stay presents inpatient providers with many of the same challenges that occur in the emergency room. The transition between inpatient and outpatient settings involves similar hurdles. Inpatient providers are also hampered by limited resources within the community, with evidence-based programs like DBT, ACT, and AOT in limited supply. Even when patients are appropriately placed in outpatient settings, provider-to-provider sign-out is a rarity.

These transitions in care are a daily concern in any healthcare system, but are particularly frequent at Bellevue Hospital Center in New York City, where literally tens of thousands of them happen each year. Bellevue includes one of the busiest psychiatric emergency rooms in the country, eight adult inpatient units, and a large outpatient clinic. This workshop will take advantage of the clinical experience of directors and administrators from each of these settings, along with the chief of psychiatry for the hospital. We will present a case that follows a patient from the emergency room to admission and through discharge to the outpatient clinic. The case will bring up many of the challenges in providing high quality and efficient care, with panel members contributing their unique clinical and administrative perspectives on transitions to and from their settings. They will describe not only the problems inherent in these transitions, but also on the innovative solutions they have created to address these important issues and improve quality of care.

HUNGER AND FOOD INSECURITY AS A MENTAL HEALTH ISSUE: EMERGING EPIDEMIOLOGICAL RESEARCH AND AN INSTITUTIONAL RESPONSE TO THE PROBLEM
Chair: Michael J. Sernyak, M.D.
Presenters: Hilary K. Seligman, M.D., Marydale DeBor, J.D., Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Attendees will understand the scope of the problem of food insecurity among individuals living with serious mental illnesses and the range of impacts that poor nutrition and food insecurity can have on the health status of psychiatric patients.; 2) Attendees will learn about the screening tools available for the 'diagnosis' of food insecurity.; 3) Attendees will learn about methods for providing nutrition support and food insecurity remediation in the context of a community mental health center with (and for those without) a primary care clinic.; 4) Attendees will recognize the need for additional attention by clinicians, as well as research on and development of evaluation methods for nutrition education, counseling, and food insecurity remediation interventions to address physical and psychological well-being.

SUMMARY:
A nutritionally sound and adequate diet is essential to the overall well-being of all people. Emerging research suggests the profound impact of general health status, obesity, and chronic disease on health care services utilization, as well as the specific impact of poor nutrition, hunger, and chronic food insecurity on psychological status. This workshop will offer a review of the research on the links between food insecurity and mental illnesses. Additionally, a case study of the Connecticut Mental Health Center's initiative to transform its food service operation for patients, employees, and visitors will be presented. This initiative incorporates education, counseling, and skill development to address nutrition needs and food insecurity.

MENTAL HEALTH ASPECTS OF EBOLA RESPONSE: SUPPORTING THOSE CLOSE AND FAR
Chairs: Sander Koyfman, Grant Brenner

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understanding of mental health issues providers face day to day in the line of duty taking care of the large scale epidemic such as the current Ebola outbreak.; 2) Understanding of issues medical volunteers face upon return and reintegration back to "civilian" life after serving on the front lines in Africa and at home.; 3) Providing any effected person (a provider or a family member) with coping tools to deal with isolation and corresponding mental health strain that may arise from quarantine orders in effect.; 4) Risk communication and policy principals as apply to dealing with Ebola and similar outbreaks now and in the future.

SUMMARY:
Numerous organizations in United States have been involved in Ebola response. From non-profits such as "More than Me" doing direct work in Africa to New York City Health Department monitoring individuals due to potential Ebola exposure. Disaster Psychiatry Outreach has formulated a strategy in addressing the mental health needs of these individuals and organizations.

Disaster Psychiatry Outreach (DPO) is a well-established non-profit organization that works to alleviate suffering in the aftermath of disaster through the expertise and good will of psychiatrists. To fulfill this mission, DPO responds to catastrophes and provides education and training in disaster mental health to a range of professionals in the healthcare, public health and emergency management sectors. We are able to:

1. Organize psychiatrists who provide immediate mental health services in the aftermath of disasters in coordination with government and private charitable organizations;
2. Develop and implement educational programs, training, and referral mechanisms, and;
3. Contribute to research and policy development in the field of disaster mental health.

DPO's activities are guided by its vision to reduce and even prevent the development of mental illness after disaster.
For over a decade, DPO has responded to New York's most acute disasters including Hurricane Sandy and the 9/11 terrorist attacks.
Explanation of Services

1. Ebola related Patient Care issues and Support via telemedicine solutions.
2. Training of direct responders in psychological first aid basics.
3. Risk communication basics training for the NYC administrators around major health care facilities to assist with staff wellness and patient care coordination.
4. Formulating strategies on reintegration upon return from Ebola related work to regular duties.

ACCESS TO CARE FOR PATIENTS WITH SUBSTANCE USE DISORDERS: DUAL DIAGNOSIS,, INPATIENT TREATMENT, AND MAT
Chair: Laurence Westreich, M.D., M.D.
Presenters: Eric Collins, Richard N Rosenthal, M.D., Laurence Westreich, M.D., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify barriers to care for the addicted and dually diagnosed person.; 2) Recognize common strategies used by third party payers to control costs in the treatment of addicted patients.; 3) Distinguish between various barriers to the use of Medication Assisted Treatment (MAT) for the addicted person.

SUMMARY:
This session will explore the various barriers to care that addicted and dually diagnosed people face, and propose solutions for clinicians as well as government, insurance companies, and treatment facilities. Patients diagnosed with Substance Use Disorders, or dually diagnosed
with addiction and another mental illness, face myriad barriers to care. Although financial barriers are the most commonly addressed roadblocks to receiving care, stigma, antiquated treatment systems, and cultural misunderstandings about addiction all contribute to difficulties in achieving broad access to care for addicted people. Although the idea of "Dual Diagnosis" has taken hold amongst clinicians, this improved clinical understanding has not transferred as quickly as it should to the courts, third-party-payers, government agencies, and the general public. Similarly, sophisticated addictions outcomes research has laid the groundwork for
better treatment selection, but the struggles between entrenched philosophies of care which promote inpatient rehabilitation, or peer-support groups, or medications, remain. A special case of this sort of inter-necine warfare is the tension between those who support the use of MAT, and those who do not. This session will provide data where possible, informed opinions where it is not, and elucidate the best course in removing barriers to effective care for addicted and dually-diagnosed people.

OCTOBER 11, 2015

HARNESSING THE POWER OF MENTAL HEALTH TO ADVANCE THE MANAGEMENT OF PEOPLE WITH SERIOUS MENTAL ILLNESS

Chair: Bernadette Cullen, M.B.
Presenter: Michele Ybarra, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify how eHealth has advanced the treatment of those with medical illnesses; 2) Recognize the access that patients with serious mental illness currently have to technology; 3) Identify ways to incorporate eHealth into the management of patients with serious mental illness in the clinic setting.

SUMMARY:
The New Freedom Commission on Mental Health 2003 called for "enhanced use of technology" in the management of those with mental illness. Over the years there have been many published studies that have reported on the effectiveness of eHealth in managing psychiatric disorders including panic disorder, depression and schizophrenia.

Despite evidence that technology can be well integrated into clinical care, it is still underutilized in the clinic setting. There may be a number of reasons for this, including:
1. Lack of dissemination of information on the effectiveness of technology in the clinic setting
2. Uncertainty regarding patients ability to access various forms of technology
3. Concern about the resources needed to deliver technology-based services and
4. Concerns about preserving patient confidentiality and HIPPA implications.

In this workshop the speakers will:
1 Review how eHealth has been successfully implemented to improve the treatment of other diseases (e.g. HIV). The speakers will give a demonstration of how technology can be used and this demonstration will involve audience participation.
2.Provide data that quantifies the access to technology among a community psychiatry clinic population. The speakers will present the results from a recent survey conducted at the Johns Hopkins Community Psychiatry Clinic. Access to cellphones, computers and the internet were compared between patients attending the clinic and a general population sample of over 1000 adults who reside in the same geographically area as the clinic.
3. Discuss ways to feasibly integrate technology treatment services into the community psychiatry clinic setting.
4. Discuss barriers to implementation that providers may face e.g. building the necessary infrastructure, protecting confidentiality and engaging stakeholders.

PERSONAL SAFETY IN THE WORKPLACE
Chairs: Mustafa A Mufti, M.D., Mary E. Diamond, B.A., D.O., M.A., M.P.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the ethical dilemmas of self-defense by Psychiatrists; 2) Understand if should we take measures to ensure our own personal safety and if so what measures; 3) How to create an environment that is safe and secure, yet therapeutic and welcoming to patients and their caregivers.

SUMMARY:
Safety in the workplace is important for both the consumer and the employees. Safety issues may arise as a result of intimidation, harassment, verbal, or physical assault. According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI), of the 4,547 fatal workplace injuries that occurred in 2010 in the United States 506 where workplace homicides. It is estimated that annually approximately 2 million Americans report being victims of workplace violence. Workplaces that may be more prone to acts of violence include facilities where money is exchanged or environments that may deal with volatile or unstable individuals. It is documented that employees such as delivery drivers, customer services agents, law enforcement personal, and healthcare workers are at a higher risk of workplace violence.

As mental health workers we often work with patients who may present with unpredictable, erratic behaviors and often have facilities that maybe located in high crime areas. Additionally, we may also come across disgruntled caregivers who feel their family members or loved ones did not receive care that met their expectations.

In July 2014 there was an unfortunate incident that arose after a psychiatric patient shot dead a caseworker in hospital near Philadelphia, PA. The situation was defused after his psychiatrist shot the patient in self-defense, which later resulted in the patient's death. This incident brought to light the complexities' and conflicting ethical dilemma of employees acting in self-defense. As physicians we all work to promote life and overall health, but in this situation the measures taken in self-defense lead to a tragic consequence. However, one may argue that had this intervention by the psychiatrist not occurred there could have been a larger loss of life had the shooter gone on to kill others?

A TALE OF THREE CLINICS: INTEGRATING PSYCHIATRY INTO ACADEMIC TEACHING CLINICS
Chair: Mary T. Gabriel, M.D.
Presenters: Jaina Amin, B.S.N., M.D., Neal Goldenberg, M.D., M.P.H., Sarah Nagle-Yang, M.D., Mary T. Gabriel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) The learners will be able to discuss the underlying principles of integrated care; 2) The learners will be able to describe the elements to consider in the design and implementation of an integrated psychiatry service; 3) The learners will be able to identify 3 common barriers to Psychiatry and Primary Care integration; 4) The learners will be able to apply the aforementioned information to the implementation of their own primary care integration projects.

SUMMARY:
Over the last decade there has been increasing interest on both the academic and political fronts in the benefits of integrated care delivery. While the logistics of individual programs may vary, integrated care refers to a shift in care delivery from a fragmented, siloed approach into one of active collaboration with emphasis placed on a more proactive, rather than reactive, approach to care. This workshop will describe the development and implementation of integrated care models into academic outpatient teaching clinics in Internal Medicine, Pediatrics and Obstetrics and Gynecology. In each of these clinics, psychiatrists have been embedded with the aim of working in a collaborative manner with the primary service. Each of these three programs will be discussed with particular attention paid to the commonalities and distinctions between them, logistical and philosophical barriers to implementation and identified successes.

THE RISE OF K2: THE EPIDEMIOLOGY, CLINICAL TREATMENT AND CRIMINAL LAW ISSUES RELATED TO SYNTHETIC CANNABINOIDS IN NEW YORK CITY
Chair: Anthony Carino, M.D.
Presenters: Nitin Savur, J.D., Joanna Fried, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify innovative clinical approaches to treat synthetic cannabinoid use disorders. ; 2) Recognize criminal law issues related to synthetic cannabinoids access in the community.; 3) Describe the epidemiology of synthetic cannabinoids in New York City.; 4) Identify population health interventions to address synthetic cannabinoids in the community.

SUMMARY:
There has been a rapid rise in synthetic cannabinoid ("K2" or "Spice") use among individuals over the last two years. This rise has resulted in significant psychiatric, physical health and social consequences. We will review the epidemiology of synthetic cannabinoids in New York City and discuss how access is affected by legal, economic and social factors. An Assistant District Attorney of New York County will present the criminal law issues that affect access, distribution and prosecution of those involved in synthetic cannabinoid sales. A clinical case review of individuals with co-occurring mental health conditions and K2 addiction will be presented. We will make recommendations around the clinical treatment of K2 addiction and population based interventions to address

this condition at the level of the community. This workshop includes interactive clinical case discussions with audience participation in addition to general audience discussion.

APPLYING FOR RESIDENCIES: ERAS, PERSONAL STATEMENTS AND PRACTICAL REALITIES….THINGS YOUR VICE DEAN NEVER TOLD YOU
Chair: Stephen M. Goldfinger, M.D.
Presenters: Marshall Forstein, M.D., Ellen J. Berkowitz, M.D., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) have a clearer idea of how the process of applying for residencies really works; 2) be able to better describe ERAS, how do prepare a personal statement, and what sorts of letters of recommendation to obtain; 3) demonstrate the ability to discuss how best to schedule and participate in interviews.

SUMMARY:
The co-leaders of this workshop, who between them have decades of experience advising medical students and reviewing applications for residencies, are offering this forum as a "consumer-driven" place to bring your questions about the entire residency application process. After talking with many, many medical students, we've come to recognize that a significant number of applicants are unclear about how ERAS and the match work, and have questions about how to choose programs to which to apply, to "sell" themselves, and to best prepare their personal statement and maximize their opportunities to match with their top-choice programs.

We hope that, in this highly interactive workshop, we can allay some anxieties and help answer some, if not all, of your questions. The sorts of topics we hope you will bring for discussion and would be happy to address include:
-Do programs have a USMLE cut off? What can I do with my scores are lower than I hoped?
-How many program should I apply to?
-How far back should I go when listing community activities or research? Should I worry more about a skimpy cv or one that looks "padded"?
-How personal should my personal statement be? Are there things I should never talk about? Things I should be sure to include?
-From whom is it best to get my letters of recommendation? I've worked briefly with somebody really famousâ€¦ Should I ask her for one?
-Is there a best time to put in the application? If I wait until late fall, am I waiting too long?
-Is there a way to know how many interviews I should go on? Are there advantages to scheduling interviews at a particular time, or in a particular order?
-Who can I trust to give me honest information about programs? Are the residents who take me to dinner evaluating me as well?
We can promise that we will be able, in the space of one workshop, to answer all of your questions. We can, however, promise to be honest in our responses and to share our own experiences and perspectives.

SYMPOSIUM

OCTOBER 08, 2015

STRATEGIES FOR DEALING WITH PSYCHIATRIST SHORTAGES
Chairs: Mark Ragins, M.D., Michael A. Flaum, M.D.
Discussant: David A. Pollack, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand, compare and contrast, some of the most promising approaches to dealing with frustrating shortages of psychiatrists enough to promote them within our individual situations; 2) To understand the usages, benefits, and challenges of telepsychiatry, physician assistants and nurse practioners, and consultation models and how to combine them; 3) To appreciate the impact of these approaches on recruitment and retention strategies.

SUMMARY:
Throughout public mental health we are facing frustrating shortages of psychiatrists that are profoundly effecting our ability to serve people and our job satisfaction. Rather than focusing on the reasons for these shortages, this symposium focuses on a variety of strategies that are actively emerging, many of them very controversial, to "do the best we can with what we have". Many of these strategies are actively challenging our identity as psychiatrists, our beliefs about what makes our practices effective or not, and who we work with as team mates and colleagues.
We've brought together a diverse group of presenters to describe the practicalities of the strategies that they are developing including personal and systemic implications. Everyone has had to combine multiple approaches, since there is no "magic bullet". These approaches include:
1) A variety of strategies are being used in Iowa including mid-level providers, telepsychaitry, and consultations
2) Leveraging psychiatric resources/expertise via the collaborative care model in combination with telepsychiatry
3) Community psychiatrists working as consultant both in primary care practices and in virtual consultation modes such as by telephone and the ECHO case training clinic collaborative approach out of New Mexico
4) Psychiatrists on ACT teams frontloading time during the initial engagement phase and then supervising Nurse Practitioners to continue ongoing care as patients flow from ACT to lower levels of care
5) The APA and the government working together through the American Psychiatric Service Corps to address recruitment and retention of psychiatrists in shortage areas.
Our discussant will share perspectives of how these various strategies will interact with his state wide efforts to recruit medical students into community psychiatry in Ohio.

NO. 1
OVERVIEW OF PSYCHIATRIC WORKFORCE AND STRATEGIES
Presenter: Michael A. Flaum, M.D.

SUMMARY:
In the section, trends and current data regarding the US psychiatric workforce will be presented, along with estimates of unmet need. An overview of the types of strategies to address the predicted widening in the gap between supply and demand for psychiatric services will be discussed, along with examples of some of these strategies.

NO. 2
LEVERAGING PSYCHIATRIC EXPERTISE VIA THE COLLABORATIVE CARE MODEL
Presenter: Lori E. Raney, M.D.

SUMMARY:
The Collaborative Care Model utilizes the psychiatrist in primary care settings primarily as a consultant instead of providing traditional face-to-face evaluations. This leveraging of psychiatric expertise has demonstrated

improved outcomes and cost savings in multiple clinical trials and provides an innovative mechanism to deal with the shortage of psychiatrists.

NO. 3
PSYCHIATRY GOES VIRAL: USING CONSULTATION TO SPREAD OUR CLINICAL DNA
Presenter: Joseph J. Parks, M.D.

SUMMARY:
Many other medical specialties have used the consultation model in community practice is a strategy for making their specialty expertise available to a much larger population of patients than they could serve directly in ongoing care by themselves. This presentation will describe to community psychiatric consultation models on site co-located consultation and multidisciplinary team consultation using telemedicine (ECHO). These models provide clinical direction for individual specific patients but also teach primary care clinicians to deliver better psychiatric care to a wider variety of psychiatric conditions themselves. In both models the psychiatrist injects/infects their primary care host with psychiatric expertise.

NO. 4
STRATEGIES FROM THE DIRECTOR OF THE MENTAL HEALTH AMERICA OF LOS ANGELES (MHALA) VILLAGE
Presenter: Mark Ragins, M.D.

SUMMARY:
Nurse practitioners have become widely used as 'mid-level' prescribers working within set
parameters that rely upon psychiatrist supervision and may be difficult to apply with the complex, multiple-diagnoses patients that are common in public mental health and especially ACT settings. MHALA has organically developed a system that front loads intensive psychiatrist direct treatment time in the engagement phase â€" developing relationships, comprehensive clinical diagnoses, formulations, and treatment plans, medication strategies, and responses to repetitive crises â€" and then, after about six months, â€œflowsâ€ the patient on to either long term ACT services or lower level of services where experienced NPs can take over as the primary prescriber. Collaborative supervision is eased since the psychiatrist usually has already personally treated the patient. This set-up can also be used to train further NPs and to provide close supervision necessary when they are first furnishing medications.

NO. 5
PSYCHIATRY STEPS UP: THE AMERICAN PSYCHIATRIC SERVICE CORPS
Presenter: Kenneth S. Thompson, M.D.

SUMMARY:
In May of 2013, President Clinton, while addressing the APA Annual Meeting, suggested that psychiatry should consider self-funding an initiative to fulfill psychiatry's social mission of providing psychiatric care in settings of need. The idea of the American Psychiatric Service Corps is a potential response. It calls for the APA to establish a program to help support the National Health Service Corps and other national and state efforts to recruit psychiatrists into areas of need across the US. It also proposes to work with US and other international agencies working in an international context. This session will discuss the scope of the project, possible funding sources and steps needed to move the project forward.

DIFFERENT ACTS
Chairs: Ann L. Hackman, M.D., Curtis N. Adams, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will understand the elements of the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity instrument and how to move their team from DACT to TMACT; 2) Participants will learn various models of integration of rehabilitation services

onto ACT teams; 3) Participants will learn various models of integration of dual diagnosis services onto ACT team; 4) Participants will understand how integrating ACT teams in Health Homes will affect fidelity to the ACT model and reimbursement for ACT services; 5) Participants will understand the utility of the Life Skills Profile on an ACT team.

SUMMARY:
Assertive Community Treatment (ACT) is a fully established evidence-based practice that has undergone a number of changes over the 40+ years of its existence. Many of the newer changes involve the integration of other evidence-based practices onto ACT. Other changes include the migration of some teams from the Dartmouth Assertive Community Treatment (DACT) fidelity scale to the Tool for Measurement of Assertive Community Treatment (TMACT). We will discuss the benefits and challenges of the integration of evidence-based practices to existing ACT teams. We will address the evolution of the assessment of adherence to fidelity to ACT. We will address the integration of ACT teams into Health Homes and the impact of such integration on reimbursement and fidelity.

NO. 1
PLACING REHABILITATION AT THE CORE OF ASSERTIVE COMMUNITY TREATMENT
Presenter: Dan Siskind, M.P.H., Ph.D.

SUMMARY:
In Australia and the UK, the ACT model has been shown to be no more effective than continuing care teams in reducing hospitalisations. However, reducing frequency of mental health crises is only one part of a consumer's recovery journey. The symptoms of mental illness may not fully respond to basic clinical interventions, leading to ongoing functional impairment.
Consumers can move towards recovery from functional impairment when provided evidence based rehabilitation oriented psychological therapies.
The ACT model has been shown to be superior to continuing care teams in engaging consumers. Engagement is essential to allow consumers to participate in rehabilitation therapies.
We present an example of a hybrid ACT team operating in Brisbane, Australia, that engages with consumers to deliver evidence based rehabilitation psychological therapies such as cognitive remediation, social cognition and CBTp.

NO. 2
DUAL DIAGNOSIS TREATMENT ON AN ACT TEAM
Presenter: Curtis N. Adams, M.D.

SUMMARY:
Integrated dual diagnosis treatment is an evidence-based practice that can be added to ACT teams. We will discuss who delivers these services on an ACT team, where those services are delivered, and how to deliver them in a recovery-oriented, person centered way.

NO. 3
FROM DACT TO TMACT: RECOVERY-ORIENTED AND PERSON-CENTERED SERVICES ON ACT TEAMS
Presenter: Ann L. Hackman, M.D.

SUMMARY:
Adherence to fidelity has been demonstrated to be vital to the delivery of effective ACT services. Some teams have begun to transition from the Dartmouth Assertive Community Treatment (DACT) Scale to the Tool for Measurement of Assertive Community Treatment (TMACT). This transition leads teams to more recovery-oriented and person-centered care. We will discuss how one team has made this transition and the challenges associated with this transition.

NO. 4

ACT TEAMS WITHIN HEALTH HOMES
Presenter: Neil Pessin, Ph.D.

SUMMARY:
ACT teams are being integrated into Health Homes. Such integration can have an impact on adherence to model fidelity and on reimbursement. We will discuss present and future impact of Health Home integration of ACT teams.

NO. 5
ACT TEAMS WITHIN HEALTH HOMES
Presenter: David C. Lindy, M.D.

SUMMARY:
ACT teams are being integrated into Health Homes. Such integration can have an impact on adherence to model fidelity and on reimbursement. We will discuss present and future impact of Health Home integration of ACT teams.

NO. 6
FROM HOME-BASED TO HEALTH HOMES: ACT IN THE ERA OF THE AFFORDABLE CARE ACT
Presenter: David C. Lindy, M.D.

SUMMARY:
Since its inception in 1980, Assertive Community Treatment (ACT) has usually been funded by government payers. Even with Medicaid managed care, ACT programs have often been "carved out" so that they are funded by separate payment streams. However, the advent of the Affordable Care Act (ACA) has prompted the development of new models of payment for many community based mental health programs, including ACT. In New York State, Medicaid Redesign has encouraged the development of Health Homes, a model designed to promote integrated, quality care at lower cost. Health Homes now include ACT teams, a development that might affect ACT fidelity and traditional conceptions of the ACT mission. This presentation will examine ACT as part of Health Homes and early experience with this shift in model in New York City.

NO. 7
OUTCOME TOOLS
Presenter: Walter Rush IV, M.D.

SUMMARY:
I have been exploring a tool on my ACT team called the Life Skills Profile by doing serial evaluations every 6 months, starting at admission. I will discuss this outcome scale and some others which are being increasingly used (WHODAS, MORS)

EARLY LESSONS FROM THE FIELD: EDUCATION FOR INTEGRATED CARE ACROSS THE MEDICAL EDUCATION CONTINUUM
Chairs: Richard F. Summers, M.D., John Q Young, M.D., M.P.P.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the need for increased focus across the medical education continuum on integration of behavioral health care with primary care.; 2) Identify major trends in education for integrated care in undergraduate, graduate and continuing medical education.; 3) Implement new educational approaches to integration of behavioral health care with primary care in one's own home institution.

SUMMARY:

New approaches for integrating psychiatry and primary care include a range of models that are a central feature of strategies to transform health care. These integrated care models promise the potential to improve access and quality while lowering costs. However, for integration models to realize these goals, psychiatrists will need to achieve proficiency in new skills and become comfortable with new roles.

This symposium will review the current trends in medical school, residency and continuing medical education on educating students and trainees for their future roles integrated behavioral health care. The presentations will include survey data on the current state of the field as well as examples of innovative educational programs. Presenters will make recommendations on how to enhance learning the knowledge, skills and attitudes necessary for practicing integrated care psychiatry in settings across the medical education continuum. The topics discussed will include didactics, clinical rotations, faculty development, optimal learning venues and financing. There will be ample time for questions and discussion to allow participants the opportunity to consider how to use these ideas and approaches in the unique settings of their home institutions.

This symposium is sponsored by the APA Council on Medical Education.

NO. 1
INTEGRATED CARE EDUCATION IN MEDICAL SCHOOL
Presenter: Lorin M. Scher, M.D.

SUMMARY:
In this era of health care reform, evidence-based collaborative mental health care models are gaining traction within health care delivery systems. However, most medical students are rarely exposed to the principles of population-based mental health care. This presentation will focus on various ways psychiatric educators can expose medical students to Integrated Care principles.

Recent trends on how medical schools are incorporating integrated care perspectives. Focus on how UC Davis students are exposed to collaborative care models in the classroom and on clinical rotations. The UC Davis Dept. of Psychiatry and Behavioral Sciences has multiple faculty (C/L and dual trained) involved in collaborative care implementation and education.

Dr. Scher will discuss how integrated care education has been incorporated into the 3rd year clerkship. He will also discuss a popular 4th year elective at UC Davis: Psychiatry 421: Combined Medicine-Psychiatry Elective's.

NO. 2
TEACHING INTEGRATED CARE IN GRADUATE MEDICAL EDUCATION
Presenter: Deborah Cowley, M.D.

SUMMARY:
Educational experiences in integrated care have been offered in some residency programs and are increasingly common, given evidence for the effectiveness of integrated/collaborative care models. 78% of general psychiatry and 72% of child/adolescent program directors responding to recent surveys report offering education in integrated care to their trainees, primarily in the form of elective rotations. The range offered includes psychiatric consultation within primary care or other medical/surgical clinics, population-based approaches including collaborative care, telepsychiatry, and rotations in which trainees learn about and/or provide primary medical care to patients.

NO. 3
CONTINUING MEDICAL EDUCATION IN INTEGRATED CARE
Presenter: Mark Rapaport, M.D.

SUMMARY:
Given the imperative to implement integrated care over the next decade, educational efforts will need to extend well beyond UME and GME. To incorporate integrated care principles within this time frame, health care systems will need to equip current psychiatrists with the necessary skills. This represents a daunting challenge for continuing medical education. This presentation will briefly summarize the elements of effective CME in general and then explore the emerging strategies for training current psychiatrists in integrated care.

MOBILE MENTAL HEALTH: ADVANCES IN SMARTPHONE TECHNOLOGY, MOBILE APPLICATIONS, AND SENSORS TO SUPPORT PSYCHIATRIC SERVICES
Chair: John Torous, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify at least three areas where smartphone applications and wearable sensors can support the delivery of mental healthcare and psychiatric services.; 2) Understand patient sentiment and interest in using smartphone applications and wearable sensors to monitor their own mental health; 3) Understand the difference between passive and active data, and identify how smartphones and sensors can collect data on self-reported symptoms, behaviors, and physiological measurements; 4) Recognize the role of new data analysis techniques for processing data generated by smartphone sensors and activity logs, and examine how they can be best utilized to provide accurate patient data; 5)Understand how to evaluate the role of mobile mental health technology in community clinical practice through accurately identifying the barriers, risks, and benefits to patients.

SUMMARY:
Rapid progress in mobile technology underscores the potential of smartphone applications and wearable sensors - and, more broadly, the resulting data - for monitoring and delivering psychiatric care. This symposium explores the potential of mobile mental health for patient care through presentations on the ability and efficacy of smartphone and sensor technology to now capture real-time patient-reported symptoms, behaviors, and physiological metrics across diverse patient populations and disease states, as well as deliver real-time as-needed psychoeducation. In addition to the capabilities and potential of mobile mental health technologies, the symposium will also focus on data analysis challenges created through this wealth of data, and explore emerging solutions and current developments in these areas. Finally, we will conclude with a discussion on the role of mobile mental health data in psychiatry and review how psychiatry can best integrate such new technologies without sacrificing the importance of personalized patient care or privacy.

NO. 1
FOCUS: A SMARTPHONE SYSTEM FOR SELF-MANAGEMENT OF SCHIZOPHRENIA.
Presenter: Dror Ben-Zeev, Ph.D.

SUMMARY:
The FOCUS smartphone intervention was developed to provide automated real-time, real-place illness management support to individuals with schizophrenia. The talk will review findings from a recent study in which 33 individuals with schizophrenia used FOCUS over 30 days in their own environments. After review of positive patient feedback, evidence of symptom reduction, and preliminary efficacy of the FOCUS smartphone intervention, the discussion will feature how such interventions introduce a new treatment model which has promise for extending the reach of evidence-based care beyond the confines of a physical clinic using widely-available technologies.

NO. 2
GOOGLE GLASS, WEARABLE SENSORS, AND DATA SECURITY & PATIENT SAFETY IN MOBILE MENTAL HEALTH
Presenter: Steven R. Chan, M.B.A., M.D.

SUMMARY:
Heads-up displays such as Google Glass, wearable sensors, and smartwatches can improve the way psychiatric practitioners assess, diagnose, and intervene in mental health. We will discuss these applications, including smartwatches used in cognitive disorders and facial recognition technologies. We will also discuss findings from a recent University of California, Davis SAMHSA-funded project using Google Glass for automatic transcription and machine translation of Spanish-speaking patientsâ€™ speech. This technology will be applied towards patient videos for use within an asynchronous telepsychiatry workflow, and Google Glass heads-up display devices for

mental health professionals during patient interviews. We will also discuss the implications of such data in terms of patient privacy and data security, and outline how psychiatrists can accurately weigh the risk and benefits of mobile mental health technology in their clinical practice.

NO. 3
INTEGRATION OF AMBULATORY PHYSIOLOGICAL INDICES INTO MOBILE MENTAL HEALTH
Presenter: David Kimhy, Ph.D.

SUMMARY:
To date, the integration of mobile technologies into mental health research and treatment has focused almost exclusively on self-report psychological measures, as well as behavioral data. The talk will first review issues and challenges related to the integration of ambulatory physiological measures into mobile mental health applications. Next, we will present findings from a study focusing on the impact of in-vivo, in-situ ambulatory autonomic regulation on auditory hallucinations in individuals with schizophrenia during the course of daily functioning. Finally, we will discuss the importance of such findings for the current and future delivery of psychiatric services.

NO. 4
TRANSFORMING SMARTPHONE DATA TO CLINICALLY USEFUL INFORMATION
Presenter: Jukka-Pekka Onnela, Ph.D.

SUMMARY:
Mobile phones can collect both active and passive behavioral data from large numbers of subjects. The talk will highlight some past work in this area, and discuss how the lessons learned have informed ongoing work on smartphones and mental health. Data generated by smartphone sensors and activity logs pose some difficult data analytic challenges, calling for the development of new big data analysis and modeling tools capable of turning multiple data streams into actionable and clinically useful information.

NO. 5
SMARTPHONE SURVEYS FOR MAJOR DEPRESSIVE DISORDER.
Presenter: Patrick Staples, M.A.

SUMMARY:
Smartphones make it possible to design high-frequency longitudinal surveys for collecting clinically meaningful information in a manner that minimizes subject response burden. Using smartphone survey data collected on PHQ-9 symptoms in major depressive disorder patients, this talk examines the characteristics of such data and explores their predictive value. Discussion looks into the potential of adaptive smartphone surveys and the need for new algorithms to fully utilize such data and how such tools can facilitate less intrusive and potentially more accurate clinical assessments for psychiatric patients.

THE MEANING OF "CRISIS" AND "EMERGENCY" IN MENTAL HEALTH SERVICES: SIGNIFICANCE, SEMANTICS, SYSTEMS ISSUES, AND SOCIAL POLICY

Chair: John S. Rozel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand different perspectives on the definitions and distinctions between 'crisis' and 'emergency' in mental health and psychiatric settings; 2) Recognize impact of the potential conflicts between person/family centered definitions and system/medical/illness centered definitions; 3) Understand the differing perspectives from emergency psychiatry, emergency medicine, and the broader mental health field on the delineation between crisis and emergency services; 4) Understand how meaningful outcomes for emergency and crisis services and be measured and used to

elucidate the impact of the discipline and specialty of emergency psychiatry; 5) Understand future directions for accreditation of professionals and programs providing care to people with behavioral emergencies. .

SUMMARY:

The last decade has seen a revitalization in crisis work and, perhaps, a reconciliation between community oriented crisis work and more traditional medical models of emergency psychiatry and academic medicine. There remains substantial ambiguity and conflict about the definitions of "crisis" and "emergency." Is there any meaningful difference? Where do they overlap and should they overlap? Who "own's" the definitions health and social systems, providers, or consumers and families?

These issues will be addressed by a panel representing emergency psychiatry, emergency medicine, community psychiatry, and mental health professionals. Particular attention will be paid to the differing perspectives and the impact of conflicting and overlapping views. Implications of the different concepts on service design and delivery, funding, required expertise for staff and leadership, policy and risk management will be addressed. Practical aspects of using meaningful, measurable outcomes to show the impact of emergency or crisis services will be explored. Finally, the role of the American Association of Emergency Psychiatry in establishing professional standards for providers and institutions in delivering emergency and crisis care will be discussed as another way to help delineate the meaning of these terms. Substantial discussion by the panelists and the audience will be invited at the end of the program.

NO. 1
THE BEHAVIORAL HEALTH PERSPECTIVE: PROVIDERS, SYSTEMS, AND THE NATIONAL INITIATIVES FOR CRISIS BEHAVIORAL HEALTH
Presenter: Cheryl Sharp, M.S.W.

SUMMARY:

Emergency and crisis work in mental health is intrinsically multidisciplinary. Emergency medicine -- and, for that matter, primary care, inpatient medicine and surgery -- often function well with minimal interaction with other professions and systems. Emergencies and crises in mental health settings, however, often draw on the input and collaboration from a broad array of professions and systems. The National Council on Behavioral Health, which represents over 2000 member organizations, has been working to enhance crisis services across a broad array of settings. These initiatives, the impact on crisis and emergency service delivery, and the perspective of other behavioral health professions on crisis and emergency will be explored.

NO. 2
PUTTING RECOVERY INTO PSYCHIATRIC PRACTICE IN CRISIS AND EMERGENCIES
Presenter: Kenneth S. Thompson, M.D.

SUMMARY:

The lives of people with psychiatric challenges are, by definition, fraught with difficulties. As times, these difficulties create urgent and even emergent situations that require psychiatric interventions. Work initiated by SAMHSA has identified the core values behind these interventions that allow crisis and emergencies to be resolved in the best manner possible and to even contribute to the process of recovery and to increasing resiliency. These values include avoiding further harm, intervening in a person centered way, sharing responsibility for the outcome with the person in crisis, addressing trauma, establishing safety, building on strengths, addressing body, mind and spirit, attending to natural supports, listening to the person as a credible source and thinking about how to prevent the next crisis. How these values impact on the actual provision of crisis services will be outlined, with particular attention to the dilemma of implementing them in emergencies.

NO. 3
PROGRESSIVE AND INNOVATIVE PSYCHIATRIC EMERGENCY SERVICES
Presenter: Scott Zeller, M.D.

SUMMARY:

Though every community and health care system faces psychiatric emergencies, the spectrum of approaches nationwide to crisis care can be varied and inconsistent. This presentation will explore the multiple models of emergency psychiatric care paying particular attention to those most commonly involved with psychiatric emergency services. Psychiatrist involvement in other models including crisis intervention, crisis stabilization, peer respite, crisis residential, telepsychiatry consultation and mobile crisis team programs will also be explored. Evidence-based best practices, trauma-informed care, and innovative programs focused on treatment in the least-restrictive alternative will be discussed.

NO. 4
THE PSYCHIATRIC PATIENT IN THE MEDICAL EMERGENCY DEPARTMENT: VIEWS FROM EMERGENCY MEDICINE
Presenter: Leslie Zun, M.B.A., M.D.

SUMMARY:
For many people living with mental illness, the medical emergency department is the first line of care for emergencies and crises related to their behavioral health issues. While this is also the case for many people with other medical and surgical issues who use medical EDs as a de factor primary care provider, psychiatric illnesses create a special challenge for assessment and care in the ED. While some medical EDs have mental health services up to and including fully embedded psychiatric emergency services, most medical EDs lack such resources. What results is a dynamic interplay between the perceptions, expectations, and resources of the ED care providers and the perceptions, expectations and needs of the patients and their families? Are they congruent or incongruent?

NO. 5
DEFINING OUTCOMES FOR CRISIS SERVICES
Presenter: Margaret Balfour, M.D., Ph.D.

SUMMARY:
Crisis services are an integral part of the behavioral health system of care, yet, in an era increasingly focused on outcomes, established core measures do not exist. An important part of defining the role of crisis and emergency services is defining their intended and actual impact on the lives of the people they serve. Measures designed for other settings, such as inpatient or outpatient behavioral health and emergency medicine, are sometimes applied. However, these measures are do not capture the unique functions of a behavioral health crisis system. Furthermore, different measures are needed at the payer level and the individual facility or provider level. This presentation will include a review of the current state of outcome measurement in crisis and emergency services and introduce a framework for determining measures that can be used to describe meaningful crisis and emergency outcomes and inform continuous quality improvement efforts.

NO. 6
EMERGENCY PSYCHIATRY AS A SPECIALTY AND DISCIPLINE
Presenter: Kimberly Nordstrom, J.D., M.D.

SUMMARY:
The American Association of Emergency Psychiatry is the professional organization that champions the advancement of evidence based, compassionate care for people experiencing behavioral emergencies. New initiatives to train and certify individuals and organizations for excellence in delivering care to people with behavioral emergencies are being implemented by the AAEP. Intrinsic in this process is reconciling the defining characteristics of emergency psychiatry as a distinct professional discipline. The implications of this process on the meaning of emergency and crisis will be explored including the opportunities and challenges of maintaining consistent mission in an psychiatric organization that welcomes nonpsychiatrists.

RACIAL/ETHNIC AND SEXUAL/GENDER MINORITY TRAINING EXPERIENCES IN PSYCHIATRY: PAST, PRESENT, AND FUTURE DIRECTIONS TO IMPROVING TRAINING CLIMATE

Chair: Roberto Montenegro, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the various types of biases minority group members have confronted historically and at present time while examining the societal implications of marginalization specific to training physicians; 2) Define and identify microaggressions while recognizing the physical and mental effects of the accumulation of microaggressions; 3) Appreciate the personal steps each individual can take to redress microaggressions in the training of future psychiatrists.

SUMMARY:
The primary aim of this symposium is to survey the progress that minorities in psychiatric training have made in the last 50 years while calling special attention to modern forms of subtle exclusion and oppression based on social differences that include but also go beyond race. The aim is to increase the awareness and accountability of the impact that microaggressions can have on the wellbeing of trainees and thereupon their patients.
The first speaker, Dr. Roberto Montenegro, will provide a quick introduction on microaggressions and a review of the progress our field has made in diversifying the makeup of psychiatrists within the U.S. Following this short introduction, three APA members-in-training will share their experiences of marginalization in residency. Dr. Hector Colon-Rivera will discuss his perspectives as a Latino Puerto Rican male; more specifically, misperceptions regarding nationality, language, and in turn, ability to adequately treat monolingual English-speaking patients. Dr. Isheeta Zalpuri will discuss her experiences as a woman and International Medical Graduate and the inherent difficulties she encounters with assumptions made by colleagues and patients alike. Dr. Kevin Johnson will discuss his experiences as a black man and a self-identified gay male. Following these 45 minutes, there will be a 20 minute question-answer session followed by a short summary by Dr. Dr. Ranna Parekh, co-author of Overcome Prejudice at Work (2012), where she will discuss how to develop strategies, gain perspective, and optimize one's frustration tolerance when confronting insults, microaggressions, and prejudice.

OCTOBER 09, 2015

MY TRUE MASCULINITY: PERSPECTIVES ON TRANSMEN OVERTIME
Chairs: Amir Ahuja, M.D., Eric Yarbrough, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) The participant should be able to identify the lack of research done on the topic of trangender health and transgender workoplace policies and experiences.; 2) The participant should be able to define the terms "cisnormativity" and "trans-inclusive" and be able to apply them to the concept of an integrated workplace and healthcare system.; 3) The participant should be able to identify the role that hornomes play in the body and their physical and emotional effects on transmen, which then affect their professional lives. ; 4) The participant should be able to explain the legal status of coverage of transitioning based on occupation and state in the United States, which clearly affects the mental health of employees. ; 5) The participant should be able to identity specific ways that medical staff and administrators or faculty can work on improving the work and personal lives of transgendered people.

SUMMARY:
The literature is sparse when discussing the issues that transpeople face as professionals in the workplace, particularly in a healthcare setting. There are many issues unique to this group of individuals that are ignored. There is an overwhelming assumption, even in the healthcare fields, and even with LGBT-friendly programs, that all providers are cisgendered. This is simply not the case, and it leaves many transpeople as invisible in the professional workplace (in healthcare and in other industries). (1). Transpeople face discrimination and higher rates of social stress, resulting in more mental halth burden and emotional difficulties. In a study that paired transgender people with their non-trans siblings, researchers found that, despite being the most educated of the group, transpeople faced higher rates of discrimination at work and outside of work. They also experienced higher rates of harrasment and lower perceived social support from family and friends than their non-trans siblings (2).

This demonstrates that the challenges faced by transpeople are not limited to lower income or minority groups, but exist everywhere.

A study was done recently with longitudinal histories taken from transmen in professional healthcare settings. These men commonly reported difficulties in passing at work, coming out to their supervisors and colleagues, and the issue of disclosure with their patients (1). Another unique issue that transpeople face in this setting is the use of hormones, and their effects on emotional and physical states. This, in turn, effects job performance and can be difficult for someone transitiong while working. Another aspect of this is the issue of coverage of sex reassignment surgery and hormones through workplace insurances. If left to pay for transitioning themselves, transpeople can be left with severe financial burdens and emotional stress.

In this symposium, psychiatric practitioners share their experiences and the latest research dealing with this under-represented topic. We will discuss the current research, what needs to be explored further in the future, and our experiences with transpeople, and as transpeople, in psychiatry. We will discuss hormones and their effects on medical and psychiatric health. We will also have a discussion about best practices and ways to integrate more trans-inclusive practices into healthcare systems and academic settings. Hopefully, this will enlighten many people on a topic that is not talked about very often, and encourage attendees to look at their own facilities and practices to improve diversity and inclusiveness.

1. MacDonnell, J & Grigorovich, A. Gender, Work, and Health for Trans Health Providers: A Focus on Transmen. Journal of ISRN Nursing, 2012.

2. Factor, RJ & Rothblum, ED. A study of transgender adults and their non-transgender siblings on demographic characteristics, social support, and experiences of violence. Journal of LGBT Health Research, 2011.

NO. 1
HORMONES AND THEIR EFFECTS ON PHYSICAL AND MENTAL HEALTH
Presenter: Benjamin Davis L.C.A.T., M.A.

SUMMARY:
Transpeople have to deal with transitioning on the job when in a professional and healthcare setting. This can be difficult as the hormones necessary for transitioning have effects on physical and mental health that are often ignored. This talk will shed some light on this topic.

NO. 2
PERSPECTIVES ON TRANSMEN CLIENTS OVERTIME
Presenter: Eric Yarbrough, M.D.

SUMMARY:
This presentation focuses on a psychiatrist in the midst of the LGBT community who shares experiences with transmen as colleagues and patients, to bring a different perspective on what the unique challenges are for these individuals and what can be done to make the workplace and healthcare settings more welcoming and comfortable for all transpeople.

NO. 3
PSYCHIATRIC PERSPECTIVES ON TRANSMEN
Presenter: Amir Ahuja, M.D.

SUMMARY:
This presentation will summarize the psychiatric stances on transmen in terms of what the lives of transmen as professionals involves emotionally and mentally.

PROMOTING OUR FUTURE LEGACY FOR COMMUNITY PSYCHIATRY

Chair: Mark Ragins, M.D.

Discussant: Mardoche Sidor, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand how several important currents of change including training changes, population health, funding, recovery, and integration with community health - have impacted our daily practices.; 2) To better appreciate accomplishments community psychiatry has made - and each of us has individually made - within each of these currents to apply them to improve our current practices ; 3) To have a wider frame of reference from which to actively participate in local programmatic and practice changes and to evaluate various job opportunities.; 4) To be an informed participant in this time of wdiespread changes, both crises and opportunities.

SUMMARY:
Community psychiatry is at our most important crossroads since deinstitutionalization. We need to build upon the important learning and accomplishments we've made, but with the massive changes and increasing psychiatrist shortages it feels like there's a risk of it all being swept away. What contributions are we most proud of and what efforts might help sustain and promote them?
This symposium brings together leaders from a variety of important perspectives discussing how to promote our future legacy including: 1) Psychiatric education and training - focusing on system based practice and recovery principles, 2) finances and funding - how our past choices impacted our practice and how our responses to current incentives and restraints could best promote our goals and values, 3) population health - how we organize our services to meet the various needs of our community, 4) recovery - how our psychiatric practices have been influenced by the recovery model and what teams and tools we want to emphasize as we move forwards, and 5) community health - primary care has been experiencing changes as well including health homes, chronic illness models and health promotion that share some underlying tenets with what we've been doing. Each presentation will include our recent accomplishments within a broader context, specific program and clinical tool examples, and recommendations for the future.
The discussant will be from the perspective of a psychiatrist in training, since they will have to practice within and hopefully promote the legacy we pass on to them.

NO. 1
CHANGES IN PSYCHIATRIC TRAINING: FOCUSING ON SYSTEMS BASED PRACTICE AND RECOVERY PRINCIPLES
Presenter: Stephanie LeMelle, M.D.

SUMMARY:
Training in Public/Community Psychiatry is receiving increasing attention. We will discuss how fellowship and residency training is changing the practice of psychiatry and promoting workforce development.
 In the mid 1960â€™s, fellowship training programs were developed to help psychiatrists deal with the needs of people leaving custodial care. In 1981 Columbia University started a Public Psychiatry Fellowship which set the standard for training psychiatrist to deal with the complex needs of people with SMI and/or people seeking public behavioral health care. There are now 16 fellowships nationally. We will discuss how fellowship training is evolving to meet workforce needs.
The Accreditation Council of Graduate Medical Education requires psychiatric residents to become proficient in Systems Based Practices and Community Psychiatry. We will discuss how these requirements helped to ensure that didactics in recovery oriented community/public psychiatry are now required training.

NO. 2
MONEY MAKES THE WORLD GO ROUND: THE IMPACT OF FUNDING MECHANISMS ON PUBLIC HEALTH POLICY AND COMMUNITY PSYCHIATRY
Presenter: Joseph J. Parks, M.D.

SUMMARY:
This presentation will begin with a review of the history of the change in how behavioral health services have been funded in the American healthcare delivery system and how changes in the sources of funding and the payment

mechanisms used resulted in sweeping and often unanticipated changes in the behavioral health service delivery system. These changes in the behavioral health service delivery system resulted in the birth of community psychiatry as a practice opportunity and shaped its evolution. Funding source and payment mechanism changes both fostered creativity and innovation but also frustrated the dreams and obstructed the goals of community psychiatrists. The second part of the presentation will briefly review the changes in funding sources and payment mechanisms that are arising out the current health care reform efforts and Affordable Care Act including choices that community psychiatry has in how it responds to this rapidly evolving funding environment.

NO. 3
COMMUNITY PSYCHIATRY LEGACY AS PRACTITIONERS OF POPULATION HEALTH
Presenter: Anita Everett, M.D.

SUMMARY:
Population health has been intrinsic to the design of public mental health services since the dawn of community psychiatry in the US over 50 years ago. More recently, with the emergence of Medicaid and other insurances as funding sources, there have been trends away from clinical and services responsibility for a county or catchment area. This has resulted in a fragmented and in some areas, publicly unaccountable availability of mental health and substance abuse services. The Affordable Care Act and current healthcare reform trends have stimulated opportunities for enhanced care coordination and accountability to populations of persons. The Medicare accountable care organization (ACO) is an example of such a design. Based on our legacy of services accountability that addresses needs within catchment areas, community psychiatry is positioned to assume leadership roles in the design and implementation of population based health services systems.

NO. 4
ADVICE FROM THE MEDICAL DIRECTOR OF MENTAL HEALTH AMERICA OF LOS ANGELES VILLAGE (MHALA)
Presenter: Mark Ragins, M.D.

SUMMARY:
The Recovery Movement has been a powerful and controversial force in community psychiatry for the past twenty years, moving from a predominantly antipsychiatric 'angry advocates' stance to a 'collaborative coworkers' stance. A number of community psychiatrists have become prominent in the Recovery Movement and have developed person-centered, recovery-based tools. The most important legacy of the recovery movement is a shift from 'illness-centered recovery' to 'person-centered recovery'. Recently community psychiatry has been more heavily concerned with other movements, but it would be a shame to lose the advances of the Recovery Movement in the process.
This presentation highlights seven clinical tools:
1.Person-Centered Formulations instead of Illness-Centered Diagnoses
2.Relationship-based services
3.Trauma informed care
4.Goal-driven medications
5.Shared decision making
6.Activating and empowering patients
7.Building resilience from protective factors and patient's strengths

NO. 5
WHAT THE REST OF MEDICINE LEARNED FROM PSYCHIATRY THAT WE FORGOT TO TELL THEM
Presenter: Kenneth S. Thompson, M.D.

SUMMARY:
Behind the efforts to increase access to care in the affordable care act, there is a great deal of effort to reshape the organization and delivery of health care- particularly primary health care. Much of this redesign is based on lessons learned in community psychiatric practice and applies them to primary health care. This presentation will

describe these psychiatric roots including our emphasizes on the engagement of the people we care for in their own care, the role of care managers and the notion of assertive community treatment.

TELEMEDICINE CONSULTATION AND PRESCRIBING: RULES, CHALLENGES, AND PRACTICAL SUGGESTIONS FOR CONTROLLED SUBSTANCE MANAGEMENT IN ADULTS AND CHILDREN

Chair: John H. Wells II, M.D.

Discussant: Peter Yellowlees, M.B.B.S., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Examine the climate guiding promulgation of regulations surrounding telemedicine prescribing in various regions. ; 2) Discuss the challenges of practicing as a prescriber or a medication consultant via telemedicine when standards of care are evolving.; 3) Recognize the special liabilities and responsibilities when prescribing or recommending controlled substances via telemedicine.; 4) Consider challenges when consulting via telemedicine special populations such as children and adolescents; 5) Identify challenges in developing rapport and trust with the consultee in a telemedicine relationship.

SUMMARY:
Telemedicine is a well-established mode for delivering high-quality access to psychiatric care, with a large evidence base supporting its safety, efficiency and efficacy. Telemedicine itself encompasses a broad array of technologies with the aim of improving health through the electronic exchange of medical information, from smart phone apps to real-time teleconferencing with patients in their own home. Though rules and guidelines from the regional to national level exist, they do not yet provide detailed guidance for many challenges of the practice of telepsychiatry. The prescribing of medications whether directly or by consultation is an area of particular interest to state boards and enforcement agencies at all levels and by extension, the intersection of psychopharmacology and tele-technology is of critical interest to anyone practicing telepsychiatry. This symposium brings together an expert panel with a broad range of experience in the use of tele-technologies for consultative prescribing in primary care collaborative settings, including psychiatrists from the University of Colorado Depression Center, University of California Davis Virtual Collaborative Care Project, Massachusetts Child Psychiatry Access Project, and the Louisiana Mental and Behavioral Health Capacity Project. This is a practical review of medical, legal and practice considerations in consulting for the treatment of children and adults, with special attention to the collaborative management of conditions commonly treated with controlled substances in primary care settings such as chronic pain, anxiety, and attention deficit disorders. Case examples and lessons learned will be used to illustrate methods for developing trust and rapport. Additionally, recent advances in asynchronous telepsychiatry and the use of other cutting edge digital health technologies will be reviewed.

NO. 1
TELEMEDICINE CONSULTATION AND PRESCRIBING: RULES, CHALLENGES, AND PRACTICAL SUGGESTIONS FOR CONTROLLED SUBSTANCE MANAGEMENT IN ADULTS AND CHILDREN
Presenter: Jay Shore, M.D., M.P.H.

SUMMARY:
This session will review the rules, guidelines and processes of consultation and direct prescribing of controlled substance via telemedicine.   The Ryan Haight Act and its requirements for controlled substances will be specifically reviewed in this section, as well as practical discussion of implementing clinical processes to meets its requirements.   This session will also review the challenges of consulting around pain management and chronic pain patients in telemedicine and methods to increased care coordination and collaboration in these cases.

NO. 2
PROMOTING BEST PRACTICES IN PRIMARY CARE PSYCHOPHARMACOLOGY THROUGH TELEPHONE CONSULTATION: EXPERIENCES RROM THE MA CHILD PSYCHIATRY ACCESS PROJECT
Presenter: Barry Sarvet, M.D.

SUMMARY:

The MA Child Psychiatry Access project is a public program providing telephone consultation and other collaborative services for pediatric primary care providers. The primary aim of the program is to help primary care providers to provide care, including basic psychopharmacologic treatment, to children and adolescents with psychiatric disorders of mild to moderate severity. Over time the program has been highly valued by primary care providers, who have reported improvement in their degree of confidence in their ability to prescribe psychiatric medication. Telephone consultations help primary care providers to consider the role of medication in the context of an overall treatment plan and frequently encourage primary care providers to consider psychosocial treatment interventions as a first step when indicated. Lessons learned from this program will be discussed along with implications for other telepsychiatry models.

NO. 3
VIRTUAL COLLABORATIVE CARE (VCC) AND ASYNCHRONOUS PRESCRIBING
Presenter: Lorin M. Scher, M.D.

SUMMARY:

Asynchronous telepsychiatry is a new approach to integrated care. As part of the AHRQ-funded UC Davis Virtual Collaborative Care (VCC) Project, we will present examples of the consultations and early results of the first 80 patients enrolled in this long-term randomized clinical trial that promises to develop and prove the efficacy of an entirely new model of mental health practice. We will discuss preliminary VCC data, workflow and roles needed to support the evolving mental health provider-patient relationship, with a highlight on issues related to asynchronous prescribing.

NO. 4
RAPPORT BUILDING IN TELEMEDICINE WITH AN EMPHASIS ON THE PRESCRIBING RELATIONSHIP
Presenter: Shih Y. Tan, M.D.

SUMMARY:

The delivery of consultative psychiatric care via telemedicine presents challenges in the development of rapport with patients and primary care clinicians. We will review various rapport-building techniques including effective communication and psycho-education, then discuss modifications to these techniques for telemedicine. We will use case examples to illustrate how rapport-building facilitates trust in the consultative relationship, especially when medication recommendations such as for benzodiazepines are made.

NO. 5
TRENDS IN DIGITAL HEALTH: INCORPORATING APPS TO IMPROVE PRESCRIBING PRACTICES
Presenter: Steven R. Chan, M.B.A., M.D.

SUMMARY:

Numerous smartphone apps have been developed to support the evolving mental health provider-patient relationship. As of 2014, the American Psychiatric Association, American Psychological Association, NAMI, and other groups have not yet provided guidance on selection or use of apps to support good practice. We will discuss how practitioners can select smartphone apps to incorporate into their telemedicine practice, and provide an overview of the apps available for both practitioners and patients. Finally, we will discuss trends in the digital health industry, with a highlight on apps which allow prescribers and patients to monitor response and side effects.

"MEDICAL SCREENING" FOR PSYCHIATRIC PATIENTS: WHEN TO ACCEPT OR DECLINE A REFERRAL FROM THE ER

Chair: Scott Zeller, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the main components of a patient who is considered medically appropriate for psychiatric treatment or transfer.; 2) Identify the importance of laboratory results in the medical screening process for psychiatric patients.; 3) Become familiar with techniques to improve the relationship between psychiatry and emergency medicine departments.

SUMMARY:
The concept of "medical clearance" for those patients in a psychiatric emergency or in need of psychiatric hospitalization has not been well-defined historically. Frequently the inconsistencies of different expectations can lead to disagreements between referring emergency medicine physicians and accepting psychiatric facilities or attending psychiatrists. This symposium will pair leaders in emergency medicine with experts in acute care psychiatry to help find common ground towards defining the elusive status often termed "medically clear".
The symposium will open with Michael P Wilson of the Department of Emergency Medicine of UC San Diego describing "Medical Clearance from the ER point of view". Next up will be Les Zun of Chicago Medical School lecturing on "Laboratory testing for medical clearance: what is truly necessary". Finally Kim Nordstrom of Denver Health Medical Center will speak on "Improving the relationship between Emergency Medicine and Psychiatry". There will be ample time for audience discussion and example cases.

NO. 1
MEDICAL CLEARANCE FROM THE ER POINT OF VIEW
Presenter: Michael Wilson, M.D., Ph.D.

SUMMARY:
What does the term medically clear mean? This presentation will cover medical screening in the modern emergency department.

NO. 2
LABORATORY TESTING FOR MEDICAL CLEARANCE: WHAT IS TRULY NECESSARY
Presenter: Leslie Zun, M.B.A., M.D.

SUMMARY:
Accepting psychiatrists and referring emergency medicine physicians often differ on which laboratory tests are necessary prior to admission to a psychiatric inpatient unit. Further, many psychiatric hospitals require a standard battery of tests. Are all of these expensive tests truly necessary in an era of healthcare reform? This presentation will discuss the evidence and literature as to what laboratory tests are truly necessary for psychiatric admission, and recommend best practice guidelines and algorithms.

NO. 3
IMPROVING THE RELATIONSHIP BETWEEN EMERGENCY MEDICINE AND PSYCHIATRY
Presenter: Kimberly Nordstrom, J.D., M.D.

SUMMARY:
Many psychiatric hospitalizations originate in medical emergency departments. However, the relationship between referring emergency medicine physicians and accepting psychiatrist can often be strained, with differing points of view on what constitutes an appropriately stable patient for psychiatric admission. This presentation will discuss methods to improve this important relationship, and feature guidelines and evidence-based best practices.

QUALITY IMPROVEMENT AND SO CAN YOU! HOW TO CREATE QUALITY INITIATIVES IN ANY CLINICAL SETTING
Chairs: Margaret Balfour, M.D., Ph.D., Lori E. Raney, M.D.
Discussants: Chris Cline, M.D., Rachel Zinns, Ed.M., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand basic concepts of quality improvement; 2) Understand how quality improvement principles can be applied in a variety of clinical settings; 3) Apply quality improvement principles to his/her own clinical setting.

SUMMARY:
Quality improvement â€" the continuous study and improvement of the processes of healthcare â€" is critical to helping organizations deliver care that is safe, effective, efficient, and person-centered. Healthcare organizations are increasingly being asked to employ quality improvement methodologies in order to improve care delivery; however, most clinicians lack formal training in this area. The prospect of initiating a quality improvement project can be daunting, especially to psychiatrists more familiar with academic research models. The purpose of this symposium is to reduce barriers to entry by demonstrating how quality improvement initiatives can be employed in real-world clinical practice, in a variety of settings by people with a variety of backgrounds and level of training in quality methodologies. The symposium will begin with a brief overview of quality improvement principles, followed by specific examples of quality improvement projects. Presentations will focus on how these projects were conceived, designed, and implemented, with lessons learned from successes and failures. The following discussion will focus on practical advice for those interested in implementing quality improvement methodologies at their own institution and the opportunity for audience members to bring forward ideas or projects in development.

Agenda:
Overview of Quality Improvement Principles
Margaret E Balfour, MD, PhD
The Impact of Process Re-engineering on Safety and Throughput in a Behavioral Health Crisis Center
Margaret E Balfour, MD, PhD
Using LEAN Methodology to move from restrictive interventions towards patient engagement
Jill Bowen, PhD
Renuka Ananthamoorthy, MD
Roumen Nikolov, MD
Implementation of an Academic Psychiatric Emergency Service
Erik Kinzie, MD; Eva Mathews, MD
Decreasing elopements in a youth residential facility
Jeffrey C. Eisen, MD, MBA; Satya Rao Montgomery, LICSW, PhD
Improving Quality of Depression Treatment through Center-wide Screening
Lori Raney, MD
Using Maintenance of Certification processes to promote Psychiatric Practitioner Quality Improvement Practices
Paula Panzer, MD
The Tobacco Wellness and Recovery Initiative: integrating tobacco cessation into Behavioral Health Services
Kristin Van Zant, MD
Development of a Behavioral Health Service in a Rural FQHC by the US-Mexico border
Alvaro Camacho, MD,MPH
Creating a Culture of CQI: Integrating Quality Improvement Concepts into Operational Management
Rachel Zinns, MD EdM
Discussion

NO. 1
IMPLEMENTATION OF AN ACADEMIC PSYCHIATRIC EMERGENCY SERVICE
Presenter: Erik Kinzie, M.D.

SUMMARY:
Prior to the initiation of this service, there was no specialty psychiatric service to the emergency department resulting in high admission rates and a delay in treatment for patients in acute mental health crisis. Our QI project

engaged the existing mental health social workers and emergency room physicians to develop an service that allowed for immediate onsite evaluations, improved medical clearance, and earlier initiation of treatment . This system also allowed for trainees of various levels to actively participate in clinical care while learning the intricacies of acute care psychiatry.

While our outcome measures are still in progress, early reports suggest this service was effective in decreasing the involuntary admission rate and improved the early interventions for patient in crisis (time to treatment). We will continue to evaluate recidivism, the overall admission rate, and use of seclusion and/or restraints.

NO. 2
INTEGRATING TOBACCO CESSATION INTO BEHAVIORAL HEALTH SERVICES
Presenter: Kristin Van Zant, M.D.

SUMMARY:
High rates of tobacco dependence have contributed to high rates of morbidity and mortality in people in behavioral health services. The movement toward integrated health services has shifted the responsibility of providing cessation supports into inpatient and outpatient mental health treatment programs. Philadelphia's Department of Behavioral Health led a collaborative including the University of Pennsylvania and the Department of Public Health in understanding challenges and barriers to moving toward smoke-free environments, improved cessation resources, increasing cessation supports. Within our agency, Horizon House, there has been a significant cultural change leading to greater awareness and support of tobacco cessation efforts. We now have a quality improvement effort to identify smokers at intake, provide resources, identify stages of change, provide NRT's, offer groups, and measure outcomes. Tobacco cessation is now integrated and measurable.

NO. 3
USING LEAN METHODOLOGY TO MOVE FROM RESTRICTIVE INTERVENTIONS TOWARDS PATIENT ENGAGEMENT
Presenter: Jill Bowen, Ph.D.

SUMMARY:
Focusing on the goal of reducing aggression rates and restrictive interventions (including IM medications and restraint use) and engaging patients in person-centerd, recovery-oriented treatment, Lean performance improvement principles and techniques, including A3 thinking, problem solving and Rapid Improvement Events (RIEs) were employed. Processes were developed which contributed to culture change, yielding results in the reduction of restrictive interventions and an increase in patient engagement strategies. During the course of this transformation major safety initiatives were identified and implemented. The evolution of lean work has extended the scope of restrictive intervention reduction efforts into staff wellness and trauma informed care, as well as psychosocial rehabilitation programming.

NO. 4
DECREASING ELOPEMENTS FROM YOUTH RESIDENTIAL FACILITIES
Presenter: Jeffrey C. Eisen, M.B.A., M.D.

SUMMARY:
Elopements, commonly known as "runs," from youth residential facilities present significant challenges and risks for both the youth and behavioral health staff involved in such events. These events also gain the attention of external constituents, such as police and payers, who also become involved as the concerns escalate. After an increased number of runs were identified across three youth residential programs, a collective team formed to develop a quality improvement initiative to reduce the frequency and severity of elopements, mitigate the youth-specific risks associated with runs, and develop innovative strategies to improve upon current practices. This presentation will describe the complexity of the identified problem, quality-based methods undertaken by the team, and outcomes achieved to date.

NO. 5
USING MAINTENANCE OF CERTIFICATION PROCESSES TO PROMOTE PSYCHIATRIC PRACTITIONER QUALITY IMPROVEMENT PRACTICES
Presenter: Paula G. Panzer, M.D.

SUMMARY:
Psychiatric practitioners in our community have very limited time to monitor their practices. We used the maintenance of certification process to identify key clinical areas needing attention: 1) challenges in using benzodiazepines; 2) the impact of concurrent substance use; (3) metabolic monitoring for clients on anti-psychotics; and 4) intervention plans and clinical outcomes monitoring for cases with pre-diabetes and diabetes. We then offered the opportunity to obtain continuing education on one of these areas then linked the new knowledge to a clinical change process with selected clients over a 6-month period. Outcome measures include pre/post training knowledge; improvements in documentation based upon standard quarterly chart review tool; improvements in linkages between medication selection relative to diagnosis and treatment goals, identification of substance use, metabolic monitoring and use of data obtained in case formulations and treatment plans.

NO. 6
BEHAVIORAL HEALTH SERVICES IN FQHCS. MEASURING OUTCOMES ACCORDING TO HRSA
Presenter: Alvaro Camacho, M.D., M.P.H.

SUMMARY:
In 2014, HRSA awarded close to 54 million dollars in grants to promote behavioral health integration services in several FQHCs nationwide. The main purpose of this grant is to determine the feasibility of creating behavioral health services within community health centers. In order to measure outcomes, FQHCs need to develop procedures to capture these data among patients attending these clinics. Objective: Describe the feasibility of incorporating common measures of depression, anxiety and manic symptoms as well as level of disability into the daily screening of patients in a rural FQHC by the US-Mexico border. Identify culturally sensitive mechanisms to reduce the stigma of receiving mental health treatment in a community mental health center as well as capture data for outcomes. Results and Conclusion: Participants will learn about the challenges of capturing data among low-literacy patients and educate staff about the importance of capturing data for quality and sustainability

MEDICAID REDESIGN IN NEW YORK STATE: CHANGING PRACTICE, CHANGING LIVES
Chair: Neal Cohen, M.D.
Presenters: Ann Marie Sullivan, M.D., Thomas E. Smith, M.D., Richard A. Sheola, M.A., M.P.A., Gary Belkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the collaborations needed to shift from a hospital-based to a community-based system of public sector mental health care.; 2) Understand the role of health home care management in maintaining a person-centered and recovery oriented model of mental health care.; 3) Identify different program models of integrated care delivery to those with co-occuring mental and physical health care needs.

SUMMARY:
Beginning in 2011, New York State launched a major initiative to fundamentally restructure the nation's largest Medicaid program. Through the efforts of a Medicaid Redesign Team, the Medicaid program was set on a path toward achieving the "Triple Aim: better care, better health and lower costs". The implementation strategies include: care management for all through Health Homes for high needs Medicaid members; prioritizing a more advanced primary care model that offered integration with behavioral health services; and, access to services that address the social determinants of health such as supportive housing, supported employment and supported education programs. With federal savings of $17.1 billion by Medicaid redesign reforms over the first 3 years, New

York State was granted a waiver amendment in 2014 to allow for a reinvestment of $8 billion to more permanently restructure its health care system with the goal of reducing avoidable hospital use by 25% over 5 years. In April 2014, seriously mentally ill New Yorkers who were previously exempted from Medicaid Managed Care requirements were now to be fully enrolled in the program including assignment to Health and Recovery Plans (HARPs) with each member having a patient-centered, recovery-oriented service plan that would address needs for health and behavioral health services in a more integrated model of care, comprehensive care management through a Health Home, and potential eligibility for Home and Community Based Services including employment, educational, and peer supports.

The workshop will provide an overview of how this major restructuring of New York's Medicaid program is impacting the lives of those with behavioral health needs including the seriously mentally ill just six months after its implementation. Is the program making progress in delivering care that is less fragmented and less "siloed" than the traditional health care delivery system? What are the challenges to the mental health provider community to deliver this new model of care? How will a new payment system that is performance based impact the landscape of the mental health provider community?

The presenters include both the New York State and New York City commissioners of mental health who have been leading the policy and implementation of the new model. Another presenter, a managed care plan executive, will provide a perspective on how the managed care industry is adapting its focus to address the needs of its members with serious mental illness. The workshop provides a preview of how other states will need to re-align its health and behavioral healthcare delivery systems to respond to the triple aim of better care, better health, and lower costs.

OCTOBER 10, 2015

HIV PSYCHIATRY TODAY
Chair: Lawrence M. McGlynn, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn approaches to diagnosis and treatment of HIV-Associated Neurocognitive Impairment/Disorder. ; 2) Understand the impact of substance use and coinfection with hepatitis C on HIV care. ; 3) To recognize common drug interactions between HIV medications and psychotropic medications. .

SUMMARY:
To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the complex biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Good clinical care can frequently be impeded by the presence of subtle cognitive impairments, substance use disorders, or coinfection with Hepatitis C. New medications with new side effect profiles make treating HIV-infected persons with a psychiatric illness increasingly complex.
This session will provide the most up-to-date information on diagnosis and treatment of cognitive disorders, the impact of prescription drug and methamphetamine use on care, new treatments for hepatitis c and syphilis, and the safest psychotropics to use with some of the new HIV medications.
The session will include a lecture followed by an interactive question and answer period providing participants the opportunity to discuss individual clinical concerns.

TELEPSYCHIATRY ESSENTIALS: EVERYTHING YOU WANTED TO KNOW ABOUT TELEPSYCHIATRY BUT WERE AFRAID TO ASK
Chair: Jay Shore, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) gain an understanding of the field of telepsychiatry including the history of its development, the scientific evidence supporting its use and current issues facing the field including reimbursement and policy issues.; 2) learn about administrative and clinical issues relevant to participating in telepsychiatric services including legal, credentialing, technology use and selection,

safety issue and adaptation of clinical styles and interventions to the modality.; 3) learn about the process for developing telepsychiatry service(s) for both individual and organizational practices.

SUMMARY:
The field of telepsychiatry, in the form of live inter-active videoconferencing, is rapidly expanding to multiple settings and aspects of psychiatric practice. This symposium brings together national experts to provide an overview of key concepts, issues, and pearls for providers, administrator and organizations interested in developing telepsychiatric services. The symposium will begin with a brief introduction to the topic as well as an update on the APA's Board of Trustees AD HOC Telepsychiary work group. A series of interactive presentations will highlight essential issues and concepts in engaging in telepsychiarty each illustrated with relevant individual and programmatic case presentations. Topics to be covered included the historical development of telepsychiatry and its current evidence base, selecting and navigating videoconferencing technologies, regulatory issues impacting service delivery, national and state-based policy and reimbursement considerations, tailoring clinical style and interventions for videoconferencing at a patient level, managing emergency concerns and a quick guide for the development of telepsychiatry services and programs. Specific hot topics to be addressed including prescribing of controlled substances, interstate licensure, and how the "use of the virtual space" in telepsychiatric care. Interaction between the audience and presenters will be encouraged throughout the symposium including question and answer after each presentation as well as at the end of the session.

NO. 1
THE STORY OF VA TELEPSYCHIATRY: HOW TELEPSYCHIATRY'S GROWTH HAS SHAPED PROGRAM DEVELOPMENT.
Presenter: Linda Godleski, M.D.

SUMMARY:
This presentation will use the VA's Telepsychiatry Programs to introduce the audience to telepsychaitry, provide a history of the development of telepsychiatry and review the current body of scientific evidence supporting its clinical use. The VA's Telepsychiatry Program, one of the world's most active telepsychiatry services, demonstrates the growth of telepsychiatry and has paralleled important trends in the field such as increasing access to remote population, adaptation of standardized psychiatric treatments and the development of direct in-home services.

NO. 2
VIDEOCONFERENCING USES AND INTEGRATION WITH OTHER TECHNOLOGIES PSYCHIATRY
Presenter: Steven Daviss, M.D.

SUMMARY:
The presentation will review the technological aspects of videoconferencing to include connectivity, bandwidth needs for various clinical applications, desktop versus web-based videoconferencing platforms, and security requirements. The integration of other technologies into videoconferencing will be discussed. These technologies include electronic medical records, email, virtual treatment and web-assisted treatments.

NO. 3
LICENSURE, PRESCRIBING AND OTHER REGULATORY ISSUES IMPACTING TELEPSYCHIATRY
Presenters: Robert Caudill, M.D., John H. Wells II, M.D.

SUMMARY:
The practice of telepsychiatry often involves the crossing of state lines, creating licensure, malpractice and standard of care issues. The presentation will review current licensure issues in telepsychiatry including the interstate compact pilot underway. We will also address the complicated issue of prescribing controlled substances through videoconferencing, the regulatory issues impacting this practice and solutions for complying with regulatory requirements.

NO. 4
REIMBURSEMENT, NATIONAL AND STATE-BASED POLICY ISSUES IN TELEPSYCHIATRY
Presenters: Ira Bergman, M.D., Alexander H. von Hafften, M.D., Jeffrey I. Bennett, M.D.

SUMMARY:
This panel discussion will address national as well as state level policy issues impacting the development and practice of Telepsychiatry. The important issue of reimbursement for Telepsychiatry services will be discussed including current reimbursement structures along with future expectations and needs. Case examples of Telepsychiatry policy and reimbursement will be presented for Alaska, Illinois and New York to illustrate, compare and contrast the impact of policy in different communities. At least some discussion will center on the role state district branches can have and have had in advocacy, education, and policy development.

NO. 5
ADDRESSING CLINICAL ISSUES IN TELEPSYCHIATRY: MANAGING SAFETY AND MODIFICATION OF CLINICAL STYLE AND PROCESS
Presenters: Peter Yellowlees, M.B.B.S., M.D., Meera Narasimhan, M.D.

SUMMARY:
This audience interactive presentation will give an overview of adapting clinical style and process when providing treatment over videoconferencing. Pearls on presenting one's self and adapting clinical style for videoconferencing will be demonstrated, including modification of style and technique for different populations (age, gender, cultural). A detailed presentation will be given on managing safety and emergency issues over telepsychiatry with patients drawing upon both and individual patient case as well as lessons from a large emergency telepsychiatry service.

NO. 6
A QUICK FIELD GUIDE FOR DEVELOPING TELEPSYCHIATRY SERVICES
Presenter: Donald Hilty, M.D.

SUMMARY:
Drawing on the example of a mature telepsychiatry service, this presentation will provide an overview of key steps for developing telepsychiatry. These include conducting a needs assessments, creating a development plan, identify funding and resources and following a clear clinic development model and strategy. Concepts around ongoing and iterative program development will be shared.

POSITIVE PSYCHIATRY ACROSS THE SPECTRUM
Chairs: Dilip V. Jeste, M.D., Samantha Boardman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the characteristics of positive bio-psycho-social factors such as resilience, optimism, and social engagement; 2) Learn the application of psychotherapeutic interventions in regular clinical practice that seek to enhance well-being; 3) Use techniques to teach the concepts of Positive Psychiatry to trainees and colleagues.

SUMMARY:
Psychiatry has traditionally been defined and practiced as a branch of medicine focused on diagnosis and treatment of mental illnesses. This definition warrants expansion to include the concept of Positive Psychiatry "the science and practice of psychiatry that seeks to understand and promote well-being through assessment and interventions involving positive psychological attributes in people who suffer from or are at high risk of developing mental illnesses. Positive Psychiatry includes positive mental health outcomes (e.g., well-being) as well as positive psychological traits such as resilience and hardiness, optimism, social engagement, and wisdom. These traits are associated with significant positive health outcomes that include better overall functioning, reduced susceptibility to cardiovascular, metabolic, and other physical diseases and depression, and greater

longevity. This symposium will focus on defining and describing resilience as well as other positive traits and outcomes such as reduced perceived stress. Additionally, there will be a discussion of the neurobiology underlying these constructs and also of various interventions to enhance well-being that are pragmatic and can be used in regular clinical practice. By strengthening the development of positive traits though psychotherapeutic, behavioral, psychosocial, and eventually biological, interventions, Positive Psychiatry has the potential to improve health outcomes and reduce morbidity as well as mortality in people with mental as well as physical illnesses. Thus the Positive Psychiatry of future is likely to be at the center of overall healthcare.

NO. 1
WHAT IS POSITIVE PSYCHIATRY?
Presenter: Dilip V. Jeste, M.D.

SUMMARY:
Positive Psychiatry may be defined as the science and practice of psychiatry that seeks to understand and promote well-being through assessment and interventions involving Positive Psychosocial Characteristics (PPCs) in people who suffer from or are at high risk of developing mental illnesses. It can also benefit non-clinical populations. It has four main components: (I) Positive mental health outcomes, (II) PPCs comprised of psychological traits and environmental factors, (III) Biology of Positive Psychiatry constructs, and (IV) Positive Psychiatry Interventions including preventive ones. There is empirical data to suggest that positive traits may be improved through psychosocial and biological interventions. As a branch of medicine, rooted in biology, psychiatry is poised to provide major contributions to the positive mental health movement, thereby impacting the overall healthcare of the population.

NO. 2
POSITIVE PSYCHIATRY OF YOUTH
Presenter: David C. Rettew, M.D.

SUMMARY:
There is mounting evidence that most of child psychopathology exists along a continuum with wellness, and many health promotion domains such as nutrition, exercise, positive parenting, and mindfulness have been shown to be useful for children who meet criteria for psychiatric disorders. This presentation will briefly review the scientific evidence supporting positive psychiatry interventions in youth. A clinical model that incorporates elements of positive psychiatry in the assessment and treatment of families will be described.

NO. 3
POSITIVE PSYCHIATRY IN ETHNIC/RACIAL MINORITY GROUPS
Presenter: Maria J. Marquine, Ph.D.

SUMMARY:
Hispanics and African Americans tend to be disadvantaged on a number of socio-demographic characteristics that place them at risk for poor mental health. Yet, as a group, they tend to have an array of cultural tools that equip them to cope with stress and life challenges, including increased religiosity/spirituality and social connectedness. Recognizing and fostering these elements might be useful for increasing well-being and enhancing mental health in these vulnerable segments of the U.S. population.

NO. 4
TRAINING IN POSITIVE PSYCHIATRY
Presenter: Richard F. Summers, M.D.

SUMMARY:
This presentation will provide an overview of positive psychiatry educational approaches as well as specific examples. Important content areas include: techniques for enhancing positive affect in interviewing, approaches for assessing strengths, including use of rating scales, techniques for enhancing and developing strengths, and

integrating the assessment and treatment of strengths and illness. The use of positive affect and strength identification in clinical supervision, and appreciative inquiry in organizational processes, reflect new ways of teaching, as both approaches demonstrate positive principles in action.

NO. 5
POSITIVE PSYCHIATRY IN CLINICAL PRACTICE
Presenter: Samantha Boardman, M.D.

SUMMARY:
Well-being and positive functioning are core elements of mental health. Research in the field of Positive Psychology enhances our understanding of the full range of human experience and how to achieve optimal functioning. Using the 'tools' of positive psychology, psychiatrists can expand their range of treatment options and better engage patients in the treatment process. A more comprehensive approach to mental health that considers the illness and also the possibility of wellness that recognizes symptoms and also sees potential can be achieved by integrating positive psychology into a psychiatrist's clinical practice.

RECOVERY-ORIENTED COGNITIVE THERAPY FOR LOW FUNCTIONING INDIVIDUALS WITH SCHIZOPHRENIA WHO HAVE DIFFICULTY INTEGRATING INTO THE COMMUNITY
Chair: Aaron T. Beck, M.D.
Presenters: Paul M. Grant, Ph.D., Aaron Brinen, Psy.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Utilize energizing strategies to engage and connect with very challenging individuals to cultivate hope and trust; 2) Set effective behavioral targets to operationalize and potentiate each person's active recovery; 3) Guide treatment with the cognitive conceptualization adapted to each person and problem .

SUMMARY:
Despite the best efforts of inpatient and outpatient providers, some individuals with severe mental illness require long-term hospital care or experience repeated hospitalization. Problems that hinder these individuals from sustaining themselves in the community include inactivity, social withdrawal, low motivation, continuous hallucinations, grandiose beliefs, disorganized behavior and aggressive actions towards others. Within a recovery-oriented framework, instructors will show how to apply the cognitive model, adapted to individuals with schizophrenia, to understand and treat these challenging problems: they will demonstrate (i) how to establish a connection (energize individuals in a non- stigmatizing manner to break through isolation, establish trust, and restart the recovery process); (ii) how to collaboratively define the recovery path (develop an individualized view of each person's aspirations, tap into latent motivation, elicit long-term goals, and create intermediate and proximal steps); (iii) how to make successful progress (establish routines to initiate, recognize, and sustain daily progress toward recovery goals); (iv) how to overcome obstacles (understand each individual's roadblocks to recovery, e.g., psychosis, low energy, aggression, self-injury, and create opportunities for mastery experiences). The workshop will be relevant to all service providers for these individuals and will be interactive, including case examples, role-plays, and videos.

INTIMATE PARTNER VIOLENCE (IPV): PSYCHIATRY'S NEGLECTED CHILD: BRIDGING THE GAP BETWEEN INTIMATE PARTNER VIOLENCE (IPV) AND MENTAL HEALTH SERVICES
Chairs: Obianuju "Uju" Obi, M.D., M.P.H., Mayumi Okuda, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Increase knowledge on the incidence and range of psychiatric disorders in victims of IPV; 2) Review treatment strategies for clients with comorbid substance use disorders and PTSD; 3) Examine models of collaboration between domestic violence service agencies and mental health care, including an ongoing public/private/academic partnership at the Bronx Family

Justice Center; 4) Report results from a survey assessing non-health care professionals' attitudes and beliefs about psychiatric treatments and barriers for psychiatric care in the Bronx Family Justice Center; 5) Explore the opportunities and challenges presented by incorporating research into a multidisciplinary collaborative clinical model with a vulnerable population of IPV victims and families. .

SUMMARY:
Intimate partner violence (IPV), which affects 20% of women, is a significant risk factor for depression and PTSD. Remarkably, there is a dearth of knowledge within the psychiatric community about how to handle, treat, and utilize resources for victims of violence. This symposium will provide an overview of the associations between IPV and psychopathology; explore the current state of collaborations between domestic violence service agencies and psychiatric treatment settings (including substance abuse); and describe a novel collaborative initiative between Columbia's psychiatry department and The New York City Family Justice Centers (FJCs), which is bringing academic medicine to IPV intervention and IPV clinical needs into psychiatry's purview.

NO. 1
CULTURAL BARRIERS IN WORKING WITHIN IPV COMMUNITY AND NOVEL STRATEGIES
Presenter: Obianuju "Uju" Obi, M.D., M.P.H.

SUMMARY:
Individuals who experience intimate partner violence (IPV) are more likely to suffer from mental health problems compared to those who do not experience IPV. Given the high comorbidity between IPV and mental health problems and the healthcare system's efforts to integrate care, collaborations between IPV agencies and psychiatric services is essential. To achieve this integration we must overcome the cultural barriers between these systems of care. This presentation will explore some of the barriers and identify novel strategies for partnerships between IPV and mental health care.

NO. 2
LEGAL SERVICES AND COLLABORATION AT FAMILY JUSTICE CENTERS
Presenter: Margarita Guzman, J.D.

SUMMARY:
The Mayor's Office to Combat Domestic Violence (OCDV), established in 2001, oversees the citywide delivery of domestic violence services, develops policies and programs, and works with diverse communities to increase awareness of domestic violence. Among several initiatives, OCDV operates the New York City Family Justice Centers (FJCs) which provide comprehensive civil legal, counseling and supportive services for victims of domestic violence, elder abuse, and sex trafficking. Located in the Bronx, Brooklyn, Queens and Manhattan, the FJCs are safe, caring environments that provide one-stop services and support and making it easier for victims to get help. This presentation will describe the range of services provided by the New York City Family Justice Centers (FJCs), and a new initiative to provide psychiatric services on-site

NO. 3
COMORBIDITY AND TREATMENT OF IPV AND MENTAL HEALTH DISORDERS
Presenter: Denise Hien, Ph.D.

SUMMARY:
There is a significant relationship between intimate partner violence (IPV), posttraumatic stress disorder (PTSD) and substance use disorders (SUD). In this presentation we will discuss the results of a NIDA Clinical Trials Network study exploring the effectiveness of two behavioral interventions for women with comorbid PTSD-SUD. Additionally, we will focus on the challenges of translating research into real life models.

NO. 4
DEVELOPMENT AND CHALLENGES OF THE DOMESTIC VIOLENCE INITIATIVE (DVI) AT COLUMBIA
Presenter: Catherine Monk, Ph.D.

SUMMARY:
Full recognition of the scope of the IPV is just one step. Our society has relegated IPV to the socio-criminal-legal sphere, where victims of violence receive social services and violent individuals are punished. Psychiatrists and psychologists are surprisingly absent from this landscape, but should engage more by integrating our clinical skills into treatment settings. The newly formed partnership between the Psychiatry Department at Columbia University and the city-run Bronx Family Justice Center (BFJC) is accomplishing this. This presentation will talk about the origins of the collaboration and address issues of cross-collaborative models of integration.

NO. 5
IMPLEMENTATION AND RESULTS OF COLLABORATIVE MODEL OF PSYCHIATRY AND BXFJC
Presenter: Mayumi Okuda, M.D.

SUMMARY:
Columbia University Department of Psychiatry and other partners that provide services at the Bronx Family Justice Center have started a new mental health collaboration. In this presentation we will describe the implementation of comprehensive psychiatric evaluations, psychopharmacologic treatment and other therapeutic modalities. We will also examine non-health care professionals' perceived needs, attitudes and beliefs about psychiatric treatment.

NO. 6
NEXT STEPS FOR EXPANSION AND DISSEMINATION ON COLLABORATION WITH ACADEMIC CENTERS AND COMMUNITY ORGANIZATIONS
Presenter: Elizabeth Fitelson, M.D.

SUMMARY:
The final presentation will focus on next steps and highlight lessons learned from this collaborative process. In addition, we will focus on how to use research and program evaluation to help improve community assessments and develop novel ideas for future expansion and dissemination.

RAISE-ETP: IMPROVING OUTCOME IN FIRST EPISODE SCHIZOPHRENIA
Chairs: John M. Kane, M.D., Nina R. Schooler, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the unmet needs in the treatment of first episode psychosis; 2) Be familiar with an evidence-based model of comprehensive care; 3) Be aware of data from a large clinical trial comparing comprehensive to usual care.

SUMMARY:
The National Institute of Mental Health (NIMH) issued a request for proposals entitled "recovery after an initial schizophrenia episode (raise)" in November 2008. The goal of the NIMH initiative is to change the trajectory and prognosis of first episode psychosis (FEP). The premise is that by combining state-of-the-art pharmacologic and psychosocial treatments in a patient-centric fashion and having them delivered by a well-trained and coordinated, multidisciplinary team, the functional outcome and quality of life for first episode patients treated in the community can be significantly improved. The specified aims of raise are, first, to develop a comprehensive and integrated intervention designed to: promote symptomatic recovery; minimize disability; maximize social academic and vocational functioning; be capable of being delivered in real world settings utilizing current funding mechanisms, and, second, to assess the overall clinical impact and cost effectiveness of the intervention as compared to currently prevailing treatment approaches and to conduct the comparison in non-academic, real world community treatment settings in the U.S.
We developed a treatment model (navigate) and training program based on extensive literature review and expert consultation. Our primary aim is to compare the experimental intervention to "usual care" on quality of life. Secondary aims include comparisons on remission, recovery and cost effectiveness. Patients 15-40 years old with

a first episode of schizophrenia; schizoaffective disorder; schizophreniform disorder, psychotic disorder NOS, or brief psychotic disorder according to DSM IV and no more than six months of antipsychotic medications were eligible. Patients are followed for a minimum of two years, with major assessments conducted by blinded, centralized raters using live, two-way video. We selected 34 clinical sites in 21 states and utilized cluster randomization to assign 17 to the experimental treatment-navigate and 17 to usual care. Enrollment began in July 2010 and ended in July 2012 with 404 subjects.

Nina Schooler will present the overall design and management of the project. Delbert Robinson will present the pharmacologic treatment model and the computerized decision support system that were implemented at the navigate sites. Kim Mueser will present the psychosocial treatment model and its implementation at the experimental sites. John Kane will present the overall results of the trial, with emphasis on quality of life, psychopathology and recovery. Robert Rosenheck will present data from cost analyses.

NO. 1
THE RAISE-ETP STUDY DESIGN, RESEARCH AND IMPLEMENTATION MODEL
Presenter: Nina R. Schooler, Ph.D.

SUMMARY:
The NIMH mandate to evaluate integrated treatment of first-episode psychosis in non-academic community settings drove study design and conduct. Thirty-four sites in 21 states were randomly assigned to provide integrated treatment (navigate) or community care. Centralized clinician/assessors, masked to treatment, evaluated clients using live two-way video. Four hundred four clients entered the study; treatment and follow-up continued for at least two years site randomization limited intervention team training to only 17 sites, meant that individuals did not have to accept randomization and maintained a clear distinction between navigate and community care. Assessment by centralized raters allowed conduct of the study at community sites without trained clinical assessors and insured masked assessments. The study demonstrates that rigorous research can be conducted in the context of us community treatment facilities.

NO. 2
ASSISTING PRESCRIBERS' EFFORTS WITHIN THE RAISE-ETP STUDY TO OPTIMIZE PHARMACOTHERAPY FOR FIRST EPISODE SCHIZOPHRENIA
Presenter: Delbert Robinson, M.D.

SUMMARY:
Navigate medication treatment was guided by compass, a computer clinical decision-making tool using a measurement-based care approach. Compass facilitated patient-prescriber communication through direct patient input of information about symptoms, side effects, treatment preferences and other issues into compass; these data guided prescribers in their sessions with patients. Compass also provided guidance about evidence-based medication strategies that informed patient - prescriber decision making about medication treatment. Compass-guided treatment was successfully employed at all 17 navigate sites. During the study, patients completed 3939 self-assessments. Over time, patients reported significant reductions in symptoms, side effects and functional difficulties and less need to change their medication regimes. We conclude that the use of computer decision support systems for the treatment of early phase schizophrenia is feasible at community treatment facilities.

NO. 3
OVERALL STRUCTURE AND PSYCHOSOCIAL COMPONENTS OF THE NAVIGATE PROGRAM
Presenter: Kim Mueser, Ph.D.

SUMMARY:
The navigate program is usually staffed by five professionals who work as a team to provide comprehensive treatment to persons recovering from a first episode of psychosis. Services provision is informed by the principles of shared decision-making, and focuses on strengths and resiliency, enhancing motivation, psychoeducation, and collaborating with natural supports. In addition to medication management, three psychosocial programs are

provided. The family education program engages the family (including the client), teaches information about psychosis, and reduces stress through consultation or skills training. Individual resiliency training helps clients pursue personal goals, while bolstering resiliency and teaching information and skills to improve illness management and goal attainment. Supported employment and education helps clients pursue mainstream educational or competitive work goals through community-based rapid school/job search and provision of follow-along supports.

NO. 4
TWO-YEAR RESULTS OF A COMPREHENSIVE CARE MODEL IN FIRST EPISODE SCHIZOPHRENIA
Presenter: John M. Kane, M.D.

SUMMARY:
Four hundred and four individuals participated in the controlled trial. The mean age was 23. The median duration of untreated psychosis was 74 weeks. Those patients who received the comprehensive care intervention "NAVIGATE" - were more likely to stay in treatment, had significantly greater improvement in quality of life, psychopathology and participation in work or school. Duration of untreated psychosis was a significant mediator.

NO. 5
COST-EFFECTIVENESS IN THE RAISE-ETP TRIAL
Presenter: Robert Rosenheck, M.D.

SUMMARY:
Monthly data were gathered through patient interviews in the raise trial on the use of health services and medications. Unit costs were estimated using data from multiple sources. Costs of training were included. The net health benefits approach (hoch et al., 2002) was used to estimate the monetized values of a one standard deviation change in the qols associated with specific probabilities that the intervention would be cost-effective.

OCTOBER 11, 2015

REIMAGINING PSYCHIATRY: MAKING THE SOCIAL CENTRAL TO TRAINING AND PRACTICE
Chairs: Vivek Datta, M.D., M.P.H., Matthew Iles-Shih, M.D., M.P.H.
Discussant: Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand the reasons for the decline of social psychiatry in the United States; 2) understand the contributions of social scientists to our knowledge of psychosis; 3) identify the barriers to and opportunities for implementation of training in social psychiatry; 4) collectively generate ideas for the implementation of social psychiatry curricula in residency training; 5) carry this forward into clinical practice, program development, community engagement, and research.

SUMMARY:
Although most psychiatry residency training programs and practicing psychiatrists identify as 'biopsychosocial' in orientation, the social dimension of this triumvirate is in decline. Despite the rich social science contributions to psychiatry that are relevant as ever to clinical practice, psychiatrists in the United States are increasingly unaware of the classic studies and recent developments emerging from this multidisciplinary milieu. Social, political and economic factors influence mental illness at every turn: from who gets sick, the form and content of their symptoms, and the illnesses they develop, the treatments that are available, the course their illness takes, and the outcome of their life-story. The social world also influences the lived experience of mental illness, including all too frequently stigma, prejudice, discrimination, inequality and exclusion. Although in recent years a burgeoning research base illuminating the importance of social factors in the etiology, course and treatment of mental illness has emerged, this has largely escaped the notice of psychiatrists despite the far-reaching implications. In their clinical training, psychiatry residents are rarely getting exposure to family intervention, social skills training, vocational rehabilitation, club houses or residential alternatives to psychiatric hospitalization. This symposium

charts the decline of social psychiatry in the United States within the context of the emergence of the politics of neoliberalism. We then survey some of the emerging social science literature locating psychosis firmly within the social space. Finally, we will highlight several existing training, research, and community programs that incorporate these core elements and serve as models for best practice.

NO. 1
WHY DID SOCIAL PSYCHIATRY DECLINE?
Presenter: Vivek Datta, M.D., M.P.H.

SUMMARY:
In the 60s and 70s, psychiatrists concerned themselves with problems of crime, racism, violence, gender inequality, human rights, war, nuclear disarmament, and how the sociopolitical influenced the mental. Though American Psychiatry's brief foray into solving the social ills of the time proved too-overarching, by the 1980s American Psychiatry had all but completely abandoned the social world, instead locating the sources of discontent not in society, community and state, but brain, cell and molecule. The remedicalization of psychiatry and the ascendance of a new biological psychiatry were intimately tied to the politics of neoliberalism, and psychiatry's increased focus on brain and biology obfuscated the wider social determinants of mental health. The failure of neuroscience and genetics to revolutionize the treatment of mental illness, the emergence of social epidemiology, and the growing concern about the widening of inequality in our society mean social psychiatry's time has come.

NO. 2
SOCIAL SCIENCE PERSPECTIVES ON PSYCHOSIS: IT'S NOT JUST ABOUT THE BRAIN
Presenter: Ippolytos Kalofonos, M.D., Ph.D.

SUMMARY:
The bio-bio-bio model of understanding and treating serious mental illness " identification of a brain lesion with a genetic cause and a pharmacological cure" has failed to provide the promised breakthroughs. Psychiatric science points to complex etiologies of often-unrelated causes: genetic risk, maternal health during pregnancy, and childhood trauma, to name a few. While psychiatry has neglected investigation of the social etiologies of psychosis, the social sciences have yielded a rich picture of the relationship of social context and psychosis. This presentation will review some of this recent research and ask what the implications might be of conceiving psychosis as not only a biochemical event occurring within neural networks, but a social event occurring within relationship networks. It will conclude with a consideration of the promises and challenges of social psychiatric research in contemporary American psychiatry.

NO. 3
PSYCHIATRY, SPACE, AND PLACE: EXPLORING THE TOPOGRAPHY OF MENTAL HEALTH & ILLNESS
Presenter: Matthew Iles-Shih, M.D., M.P.H.

SUMMARY:
In this presentation, we first describe some of the more salient insights now emerging from social epidemiology, the spatial sciences, urban studies, and planning with regard to the etiology of mental health and illness. This will, in turn, serve as a foundation for discussing an array of potential policy and design interventions related to aspects of the built environment - from the organization of inpatient wards to the design of cities. The presentation will conclude by (1) highlighting the potential for our profession to serve as advocate, advisor, and partner in such interventions and (2) describing the kinds of knowledge- and skill-sets that could be incorporated into our training to help us effectively serve in these roles.

NO. 4
DEVELOPMENT OF A MODEL CURRICULUM FOR COMMUNITY/SOCIAL PSYCHIATRY
Presenter: Stephanie LeMelle, M.D.

SUMMARY:

Residency training in psychiatry has traditionally been taught using a private practice model. Over time, our mental health systems have significantly changed and we now practice in larger systems of care. Our training programs however have lagged behind. In this presentation we will discuss the development of a model for training residents in community/social psychiatry. We will explore ways that this model can be adapted and replicated in different settings. We will also discuss the impact that this model has had on ACGME training requirements and the implications for further workforce development.

FIRST, DO NO HARM: HISTORICAL, ETHICAL, AND LEGAL PERSPECTIVES ON SEXUAL ORIENTATION CHANGE EFFORTS (SOCE)
Chair: Lorraine Lothwell, M.D.
Discussant: Jack Drescher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that lesbian, gay, and bisexual youth and adults can be subjected to so-called "therapies" aimed at changing their sexual orientation; 2) Understand that sexual orientation change efforts cause great psychological harm to individuals subjected to such practices; 3) Demonstrate ways to support and advocate for patients who were subjected to these harmful practices.

SUMMARY:

Efforts to change a homosexual orientation to a heterosexual one (sexual orientation change efforts or SOCE) have been offered to both willing and unwilling patients since the early days of modern psychiatry. However, after homosexuality was removed from the DSM in 1973, efforts to "cure" it fell into disrepute. SOCE are no longer taught in reputable training programs of any of the mental health professions and its practitioners are often unlicensed individuals on the fringes of the mental health mainstream. In an effort to explain how and why clinical and cultural attitudes have changed, this discussion takes up the history, ethics, politics and public policy issues related to sexual orientation change efforts (SOCE).

NO. 1
A DISCUSSION ON SEXUAL ORIENTATION CHANGE EFFORTS AND CIVIL RIGHTS
Presenter: Sam Wolfe, J.D.

SUMMARY:

Sam Wolfe, civil rights attorney with the Southern Poverty Law Center will discuss his case on behalf of four SOCE survivors aiming to hold practitioners in New Jersey liable for consumer fraud. Other topics will include state legislative action to stop the use of SOCE on minors and complaints or other administrative actions against SOCE practitioners for professional ethics violations.

NO. 2
ETHICAL CONCERNS ABOUT SEXUAL ORIENTATION CHANGE EFFORTS
Presenter: Tia Powell, M.D.

SUMMARY:

Legal efforts to ban Sexual Orientation Change Efforts (SOCE) have passed or are underway in many municipalities. But are these legal attempts, and the ethical arguments on which they are based, the best way to assure dignity and freedom for LGBT people? The author argues that though SOCE is a noxious and harmful practice, legal bans may not be the best approach to its elimination, particularly if those bans rest on arguments assuming the immutability of sexual orientation.

NO. 3
IS AN APOLOGY ENOUGH? DISCUSSION OF THE SPITZER STUDY AND RETRACTION.
Presenter: Milton L. Wainberg, M.D.

SUMMARY:

After 11 years since his infamous article published in the Archives of Sexual Behavior (2001) 'Can some gay men and lesbians change their sexual orientation?' 200 participants reporting a change from homosexual to heterosexual orientation',Bob Spitzer chose to apologize for his ex-gay study which had fatal flaws. The presentation will discuss his study, some of the replies to his study, his reply to the replies and his 'apology' 11 years later. The question is, is an apology enough?

MEDIA WORKSHOP

OCTOBER 08, 2015

SHIFTING THE PARADIGM: A MEDIA STUDY AND DISCUSSION ON THE ROLE OF PEER ADVOCATES IN MENTAL HEALTH TREATMENT
Chairs: Hiren Bhakta, M.D., Yona Silverman, M.D.
Presenter: Jose Vito, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the role of a peer advocate within current treatment models. ; 2) Highlight the data describing the potential effect of peer advocates in terms of treatment compliance and outcome in the SPMI population. ; 3) Discuss the benefits and risks of working with peer advocates. .

SUMMARY:
As the culture of mental health transitions from one geared towards "treatment" to a "consumer" model, there has been a move to create positions for peer advocates who work within the more traditional mental health clinics. While peer advocates and counselors have had an increasing role within substance use disorder treatment for many years, more recently they have been introduced into inpatient and outpatient facilities treating individuals with SPMI. Now, many states are creating licensing requirements for these advocates and peer positions are being created that are reimbursable by Medicaid. In this workshop we will begin with a discussion about peer advocacy programs in New York City that aim to train individuals with a history of SPMI, as well as substance and forensic histories that might preclude people from social services work, to work in support roles with agencies and hospitals. We will then present the film Short Term 12, which details the experiences of a group of high-risk children in a residential foster-care facility, viewed through the lens of the supervisor of the facility, herself a survivor of childhood sexual and physical trauma. The film explores her own struggles working with children who face similar physical and psychological dangers to those she overcame, and highlights the ways in which her experiences inform her work. Considering both the Howie the Harp program and the roles of peer advocates within the mental health system, as well as the role of the peer and survivor in the film, we discuss the ways in which peer advocates can be both uniquely suited to working with the SMI population, but also the ways in which they may be seen as "obstructionist" to care.

OCTOBER 10, 2015

"FAR FROM HEAVEN:" THE DYNAMICS OF COMPETING HOMOPHOBIA AND RACISM IN AMERICA
Chairs: Petros Levounis, M.A., M.D., Noah Villegas
Presenters: Michelle Benitez, M.D., Danilo de Jesus Been Carrasco, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe past and current social views on race and sexual orientation; 2) List three major barriers to mental health faced by LGBT people and people of different races in America.; 3) Discuss the prevalence and impact of substance use in minority and LGBT communities.

SUMMARY:
In recent years, journalism, arts, media, politics, and the relatively new field of Cultural Psychiatry have helped illuminate some of the darker corners of America's relationship with race and sexuality. However, rarely someone is brave enough to explore both racial tensions and sexual orientation at the same time. It is even rarer to find a creative mind pitting one form of discrimination directly against another. With "Far from Heaven" (2002, 107 minutes), writer/director Todd Haynes does exactly that: he forces us to experience racism and homophobia

simultaneously, question our own assumptions and prejudices, take a hard look at the history of America, while all along feeling deeply sympathetic to his characters.

"Far from Heaven" (starring Julianne Moore, Dennis Quaid, Dennis Haysbert, and Viola Davis) is a period film that centers around Cathy Whitaker, a 1950's Caucasian housewife living in an affluent Connecticut suburb. Her life quickly unravels when she finds her husband with another man and for consolation turns to the friendship of Raymond Deagan, an African American man.

The film provides poignant social commentaries on the intersection of suffering from alcoholism, being in the closet, and living in a world where homophobia and racism compete for people's hatred. It openly and unapologetically discusses social expectations vis-a-vis self-expectations as the characters oscillate between torturing and being tortured.

"I know it's wrong because it makes me feel despicable," concludes Frank Whitaker referring to his homosexual feelings. "I've learned my lesson about mixing in other worlds-I've seen the sparks fly," Raymond Deagan painfully points out.

From a psychiatric perspective, how far can Frank and Raymond go in breaking down the rules of society before they break down themselves? And if they were to conform to societal expectations, would the stress of repression be greater than that of excommunication? Furthermore, does it matter that Frank's demons seem to be ego-dystonic as he has internalized the communal homophobia, while Raymond's struggles are likely ego-syntonic as he does not agree with the racist attitudes of his environment? Finally, caught in the middle of these intensely male battles of identity and role, is the tragic character of Cathy Whitaker the heroic survivor or the helpless victim of this bigoted world?

The film is set during a time when prejudices were considerably harsher and more overt than today. As such, "Far from Heaven" offers our workshop participants a unique opportunity to study racism and homophobia "in the raw" before contemporary views on race and sexuality moved discrimination to society's more tolerant but less conspicuous underbelly. We will also examine successful-as well as dysfunctional-coping strategies that address the stress of discrimination, such as alcohol and drug use.

This workshop is primarily targeted towards members in training and early career psychiatrists.

LECTURE

OCTOBER 08, 2015

ETHICS AT THE APA: UPDATE ON THE BOARD OF TRUSTEES AD HOC WORKING GROUP ON ETHICS
Lecturer: Rebecca Brendel, M.D.

SUMMARY:
The American Psychiatric Association (APA) has based its ethics on the American Medical Association's principles of medical ethics. With these principles as a core, the APA has promulgated annotations especially applicable to psychiatry, or the annotations. Beginning more than a decade ago, APA also
Established a workgroup to develop a resource document for APA Members to supplement the existing reference materials and to assist members in understanding how the principles might be applied Against the backdrop of the changing landscape of psychiatric Practice. After substantial work by leaders in psychiatric ethics, the resource document essentially was untouched from 2008 until
2014, when, under the leadership of then APA president-elect Renee Binder, M.D. an ad hoc working group was formed to review and update The resource document.
This presentation by Dr. Brendel, who chairs the ad hoc working group, will present an overview of the APA's ethical guideposts, reviewing the principles and annotations and raising key issues in contemporary psychiatric practice with which the ad Hoc committee is grappling in developing a resource document for APA Topics covered will include the uses of technology, the role of Psychiatrists on interdisciplinary teams, unique considerations of providers practicing in small communities, boundaries, and self-disclosure. Time will be allotted for a question and answer period.

ASSISTED OUTPATIENT TREATMENT FOR PERSONS WITH SEVERE MENTAL ILLNESS: THE DATA AND THE CONTROVERSY
Lecturer: Marvin Swartz, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the existing empirical data on the effectiveness of assisted outpatient treatment; 2) Discuss the controversies about the use of assisted outpatient treatment; 3) Review data on the costs and benefits of assisted outpatient treatment.

SUMMARY:
In 1999, joined 41 other states with involuntary outpatient commitment statutes, inenacting Kendra's Law, establishing a provision for assisted outpatient treatment (AOT) for persons with mental illness at risk of relapse due to failure to adhere to recommended treatment. The goal of AOT is to improve outcomes for persons with mental illness who have difficulty engaging in mental health services, which they need to prevent their conditions from deteriorating to the point of relapse and hospitalization.
While most states had previously established identical legal criteria for involuntary inpatient and outpatient commitment, Kendra's Law became one of a small number of newer statutes that attempted to prevent relapse by setting a lower clinical threshold for involuntary outpatient commitment. Despite these supposed benign intentions, in New York and other states, AOT has become a flashpoint for controversy, especially among certain consumer advocacy and civil liberties groups. This lecture will review the
existing empirical data about the effectiveness of AOT in the United States. The controversy about the use of AOT will also be critically discussed. In addition, findings from recent evaluations of the cost and benefits of AOT will be presented and discussed. Finally APA's work on formulating a Position Statement on AOT will also be reviewed.

OCTOBER 09, 2015

STORIES THAT STICK: TEACHING FROM THE HEART USING PERSONAL NARRATIVE STIMULUS VIDEO
Lecturer: Geraldine Fox, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify several key elements of an effective stimulus video; 2) Understand how to use video clips to stimulate group discussion and promote active learning; 3) List reasons to use narrative in teaching medicine.

SUMMARY:
Purpose: The effective use of narrative stimulus video to encourage active learning in medical education will be discussed.
Methods: Dr. Fox will illustrate the use of personal story and stimulus video in teaching lifespan development, using examples from Dr. Fox's "Normal Development" video curriculum. Filmed over the course of 20 years, this video resource provides 372 brief visual anecdotes (over 12 hours of material), documenting the development of two children from birth through adolescence in the context of family and community, without voice-over narration. The clips are thought-provoking and often humorous, and are intended to engage the viewers' interest. Clips will also be shown from Dr. Fox's end-of-life video about her father, "Saying Goodbye" (38 minutes, 15 clips total), to bring full circle the discussion of lifespan development in family contexts. The presentation will be highly interactive.
Results: Comprehension, higher-order learning, and retention of concepts are improved with the use of narrative, stimulus video and active discussion.
Conclusions: Reviewing developmental theory using examples of real children growing up, in the context of family and community, enhances understanding and brings theoretical concepts to life.

CLINICAL AND FORENSIC IMPACT OF THE NEW DSM-5 DEFINITION OF INTELLECTUAL DEVELOPMENTAL DISORDER
Lecturer: James Harris, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List intellectual functions that must be clinically accessed in Criterion A for IDD in DSM-5; 2) Discuss the role of adaptive deficits in conceptual, social and practical domains of functioning in determining the severity of IDD; 3) Discuss the role of the DSM-5 definition in determining eligibility for the death penalty.

SUMMARY:
The naming for disorders of intellectual development has changed 10 times in the past century. These changes represent new knowledge and seek to preserve the dignity of affected persons. As a corrective when the terms moron, imbecile, idiot were used prejoratively the category mental retardation was Introduced In 1961. This term was used inappropriately as the R-word (retard). In 2009 "The Spread the Word to End the Word Campaign" was introduced In schools seeking to reduce stigma. In 2010 US Public Law 111-256 changed all references in US Federal law to mental retardation to references to an intellectual disability. DSM-5 formalized the name change by introducing the new term intellectual disability (intellectual developmental disorder) and a new category, neurodevelopmental disorders. Significantly with the elimination of the multiaxial classification and the new requirement of a case formulation in DSM-5 there has been a paradigm shift in the definition with less emphasis placed on IQ cut off scores and greater emphasis placed on adaptive functioning. In DSM-5 early onset Neurodevelopmental Disorders parallel late onset Neurocognitive Disorders in being disorders of brain functioning. Because of its common use in the scientific literature intellectual disability is listed but followed in parenthesis by intellectual developmental disorder to make clear that this is a mental disorder. In keeping with the disorder focus intelligence is defined and clinical assessment of specific intellectual functions (e.g. reasoning, problem solving) is required in addition to standardized intelligence testing. A number of caveats are introduced in interpreting the IQ score. IQ cut offs are no longer used in determining severity of disorder. IQ test scores are

approximations of conceptual functioning but may be insufficient to assess reasoning in real life situations and mastery of practical tasks. A person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment and other adaptive functioning that the person's actual functioning is comparable to a person with a lower IQ score. Thus instead of IQ cut off scores descriptions of adaptive deficits in conceptual, social and practical domains of functioning are used in determining severity. Gullibility is often an associated feature, involving naiveté in social situations and a tendency for being easily led by others. Gullibility and lack of awareness of risk may result in exploitation and possible victimization, fraud, unintentional criminal involvement, false confessions, and risk for physical and sexual abuse. These associated features can be important in criminal cases, especially Atkins-type hearings involving the death penalty. For example in the Hall v Florida intellectual disability and eligibility for the death penalty case the DSM-5 definition was widely referenced in the Supreme Court decision finding the Florida law unconstitutional.

PSYCHIATRY: WHAT'S WORLDVIEW GOT TO DO WITH IT?
Lecturer: Allan Josephson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the role of assessment of the patient's world view in a comprehensive psychiatric evaluation.; 2) Know that understanding the patient's world view is a key to establishing an effective doctor-patient relationship.; 3) Recognize that the clinician's world view influences the clinical encounter.

SUMMARY:
In the past generation, religion in psychiatry has moved through several stages: from a Freudian- influenced, openly vilified factor, to a forgotten factor, to a relevant variable in the current interdisciplinary openness to integrative care. There has been an exponential increase in research and
clinical literature addressing religion and spirituality, accompanied by requirements of accrediting bodies to address these factors in clinical practice. A deepening awareness of the impact of culture in all aspects
of psychiatry has furthered the importance of seeing religion and spirituality as key components of patient care. Just as the field of pastoral counseling brought psychiatry to religion, psychiatry now brings consideration of the patient's worldview to clinical practice.
This presentation stems from the work of the author and several colleagues over the past decade at numerous annual meetings of the American Psychiatric Association. In exploring how to work with the patient and his/her worldview, they found that patients often asked questions about the therapist's worldview. This observation led to a consideration of the interaction between the worldviews of patient and doctor. The body of work culminated in the publication, Handbook of Spirituality and Worldview in
Clinical Practice (APPI, 2004), now used in many psychiatry residencies to aid the integration of these concepts into the mainstream of clinical work.
This work describes worldview as the cognitive/belief component of religion and spirituality, also including the irreligious worldview. Simply, all patients and doctors have world views which may, or may not, be religiously based.
This session will consider the following:
1. The relationship of worldview to spirituality and religion.
2. The structured and unstructured assessment of worldview.
3. Integrating worldview issues into the case formulation.
4. Identifying areas of overlap between psychiatry and worldview: models of development and
5. Exploring treatment issues, including transference/countertransference in the doctor-patient models of psychopathology, including the key areas of morality, meaning and suffering. relationship and collaborating with religious/spiritual resources.

The presentation will end with a discussion of impediments in contemporary psychiatry to fully know and understand the inner world of the patient. The author will review how he understands and monitors his worldview in his clinical work.

ADVANCING PSYCHIATRIC CARE THROUGH POPULATION HEALTH MANAGEMENT
Lecturer: Joseph J. Parks, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the increase utilization and cost of medical services associated with diagnoses of psychiatric illness and substance use disorders; 2) Learn how to apply data analytics to identify high risk/high service utilization patient subpopulations with specific actionable care gaps; 3) Describe the current political, healthcare delivery, and health reform forces driving the increase demand for integration of psychiatric care with general medical care; .

SUMMARY:
Multiple analyses show that in any health care population 5% of the patients result in 80% of the costs and the majority of those patients have psychiatric and substance use disorders. Increased application of data analysis required by multiple parts of the Affordable Care Act is resulted in both commercial and governmental payers coming to the realization that patients with behavioral health conditions are the drivers of their utilization and cost challenges. This is resulted in increasing demand for psychiatric care and for the integration of behavioral healthcare in general with general medical care. The increasing demand for psychiatric services is already outstripped the available psychiatrist workforce and will get substantially worse in the near future. Our current health care delivery model cannot be adequately staffed with psychiatrists to meet the demand. For persons with multiple chronic illnesses both medical and psychiatric traditional healthcare delivery approach of depending on the patients to identify what care they need from who and when has resulted in high-cost care with poor outcomes. Population Health Management gives us the tools to transform our current high-cost poor outcome cottage industry method of healthcare delivery to a modern data analytic unsystematic healthcare delivery model that uses a combination of healthcare technology and data targeted personal relationships to change the healthcare behaviors that drive high costs and poorer outcomes. This session will present data on the extent to which psychiatric conditions are associated with high costs and poor outcomes, an overview of the growing psychiatric workforce shortage in the current health care reform environment driving increased demand for psychiatric and behavioral healthcare. The presentation will then present models of integrated health care delivery using Population Health Management tools to give psychiatrist a much wider and deeper impact on the number of patients they help in the quality of care those patients get.

PSYCHIATRY-TODAY'S FORMIDABLE CHALLENGES, OPPORTUNITIES AND RESPONSES
Lecturer: Herbert Pardes, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize major current challenges to psychiatry.; 2) Know the primary policy changes being considered in Congress that can affect psychiatry.; 3) Know some of the recent and major contributions made by leaders in psychiatry and mental health.

SUMMARY:
We are in a period in which psychiatry and mental healthcare are experiencing increasing recognition by the general community to a degree almost unprecedented in the nation's history. For example, psychiatry faces momentous challenges in the context of healthcare transformation. Yet also we are being asked to deal with indiscriminate violence often by pychiatrically ill people and major problems in the military. What are the details of these issues? What should be the responses? Psychiatry should contribute to the strengthening of the United States healthcare system and the upgrading of mental health care, education and research for those with patients and families in the tens of millions who suffer from psychiatric illness.

PSYCHIATRIC LEADERSHIP: LESSONS LEARNED "FUTURE POSSIBILITIES"
Lecturer: Carolyn B Robinowitz, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) demonstrate awareness of the challenges of such positions and what is needed to promote successful outcomes.; 2) gain an understanding of leadership roles for psychiatrists in institutions and organizations and how sociocultural changes in the 21st century have impacted these roles; 3) gain an understanding for the historical content of leadership roles for psychiatrists.

SUMMARY:
Historically, psychiatrists have been leaders in multiple clinical settings-leading treatment teams, serving as hospital and clinic administrators, as well as holding senior positions in academic medical institutions. With the advent of more complex systems and structures of care, leadership roles and authority of physicians have frequently become diluted as the purview of the non-clinician business-trained executive has expanded, such that the "business of medicine" as measured by the bottom line becomes the driver of the health care or educational system. Yet effective leadership by psychiatrist clinician executives is needed for these systems to be successful in all aspects of their mission.
Psychiatric residency programs provide some education in administration, but there are few curricula that prepare young psychiatrists for future leadership positions. Much of continuing medical- professional education focuses (not inappropriately) on specific clinical tasks, treating leadership opportunities under the old rubric of "see one, do one, teach one" even as schools of business, management, and public health develop more formal lengthy educational programs in health systems administration.
This presentation will examine the role and impact of psychiatrist leaders over the past half century using case studies and clinical examples, needs assessments and outcome data, and personal experience in a broad array of medical environments, as well as discuss the challenges for special populations such as women, people of color, etc. It will consider current opportunities for psychiatric leadership in medicine, and propose pathways and approaches for educating and mentoring young psychiatrists to become the next generation of leaders.

THE CHALLENGE OF MEDICAL PSYCHIATRIC COMPLEXITY
Lecturer: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have an increased understanding of the burden of medical psychiatric complexity; 2) Understand common errors in the management of patients with combined medical psychiatric illness; 3) Understand how current financing schemas impede optimal care.

SUMMARY:
In this talk Dr. Summergrad will present data on the burden and presentation of medical psychiatric co-morbid illness. Common errors in the evaluation and management of patients with co-morbid medical psychiatric illness will be highlighted as will challenges in providing optimal care in current health care organizations and financing schemes. Options for improvement will be presented.

OCTOBER 11, 2015

DISCHARGE PLANNING ON MENTAL HEALTH INPATIENT UNITS: WHAT'S HAPPENING AND DOES IT WORK?
Lecturer: Thomas E. Smith, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe standards of care and prevalence of routine inpatient discharge planning procedures. ; 2) Assess the impact of discharge planning practices on engagement with aftercare services.; 3) Describe patient populations that likely require more intensive care transition interventions to ensure timely follow-up after discharge.

SUMMARY:

Inpatient discharge planning practices believed to improve transitions include communication with outpatient providers, scheduling timely aftercare appointments, and forwarding discharge summaries to outpatient providers. These practices represent a standard of care, but studies of general medical/surgical discharges indicate that hospital providers complete them for fewer than 50% of discharges. In addition, little is known about how often mental health inpatient providers complete these practices and whether the practices significantly impact patient attendance at mental health aftercare services. The presenters will report data from a statewide assessment of care coordination needs and provider discharge planning practices for Medicaid patients hospitalized on mental health units. Preliminary analyses of over 30,000 discharges indicated that inpatient providers completed at least one of the 3 identified practices for the majority of discharges. Analyses confirmed significant associations between providers completing discharge planning practices and patients attending mental health aftercare services. Further analyses will identify patient subgroups that did not benefit from these practices and likely required more intensive care transition interventions. Research that determines when and for whom specific discharge planning practices are effective will allow providers to better align scarce resources to maximize quality care for a highly vulnerable population.

PSYCHIATRIC HOSPITAL READMISSION IN A JAIL SETTING
Lecturers: Christopher Racine, M.D., Elizabeth Ford, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize clinical, demographic, and systems variables that are associated with risk for readmission to a psychiatric hospital at time of discharge.; 2) Identify how limited mental health resources are being utilized for the growing population of mentally ill incarcerated individuals.; 3) Identify coordination of care efforts that may improve mental health treatment for those in jails and prisons with mental health service needs. .

SUMMARY:
Inpatient psychiatric admission, a precious and costly treatment modality, is disproportionately and repeatedly utilized by a small percentage of individuals with mental health needs. Demographic factors of those patients at greatest risk of being readmitted to acute psychiatric units have been identified for traditional psychiatric settings . A history of prior inpatient hospitalization, severe and persistent mental illness, and a lack of community support networks have all been associated with an increased risk of readmission to inpatient psychiatric settings. However, there is no information available about whether these same factors apply to an incarcerated population. The Bellevue Hospital Forensic Psychiatry Service (FPS) provides acute inpatient psychiatric care in a public hospital setting for male jail detainees in New York City. Approximately 50% of patient-detainees are discharged from the Bellevue FPS to Rikers Island, the city's largest jail complex. Approximately 7% of these individuals are then readmitted to the service within 15 days of discharge. Repeated jail hospitalizations are very costly and, in some cases, detrimental to an individual's health due to lost continuity of care . This case control study of a sample of 86 subjects readmitted to the service in the years 2010-2012 sought to identify both clinical and demographic factors associated with patient-detainees at highest risk of inpatient hospital readmission. Results showed that those patients with a psychotic or mood disorder were more likely to be readmitted within 15 days. Initial hospital length of stay did not affect the likelihood of subsequent readmission. Results from this study will help guide inpatient treatment planning efforts and coordination with Rikers Island mental health services, including encouraging better post-discharge treatment adherence, so as to minimize the risk of re-admission and ensure that limited resources are being used in the most efficient and patient-centered way.

THE ETHICS POLICE? THE STRUGGLE TO MAKE HUMAN RESEARCH SAFE
Lecturer: Robert L. Klitzman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know the ethical challenges that arise in conducting research on psychiatric and other patients; 2) Understand the ways that Institutional Review boars often struggle with these challenges; 3) Know the ways these challenges might best be addressed in the future.

SUMMARY:
Research on psychiatric patients has long posed ethical challenges. Periodically, scandals have emerged when researchers have conducted experiments on these patients, and failed to adequately protect the rights and well-being of these vulnerable individuals. Recently, for instance, the case of Donald Markingson, a patient with schizophrenia, gained wide media attention after he killed himself while enrolled as a subject in a study at the University of Minnesota. Critics of the study have argued that he did not sufficiently understand the protocol. Institutional Review Boards (IRBs) were established through the 1974 National Research Act, following revelations about ethical violations in the Tuskegee Syphilis Study. Yet increasingly, researchers and others have been criticizing IRBs for "going too far" and now impeding important research. The mounting role of pharmaceutical companies and decreasing NIH budgets exacerbate many of these strains. Moreover, the boundaries between clinical and research realms are becoming more blurred, given the rise of various forms of clinical research. This presentation will explore the underlying ethical tensions involved as IRBs wrestle to assess and balance risks and benefits, ensure that study participants understand complex informed consent forms, and that vulnerable subjects are not unduly burdened. It is increasingly vital for psychiatrists and other mental health providers involved in clinical work, as well as research, to be aware of evolving challenges.

COMMON FACTORS ACROSS THERAPIES FOR SUICIDAL PATIENTS WITH BORDERLINE PERSONALITY DISORDER
Lecturer: Eric Plakun, M.D.

Educational Objective:
At the conclusion of the session the participant should be able to: 1) Recognize components of evidence based psychotherapies for suicidal patients with borderline personality disorder 2) Understand common factors across therapies for suicidal patients with borderline disorder 3) Improve outcomes in work with suicidal patients with borderline personality disorder

Summary:
Five psychotherapies for suicidal patients with borderline personality disorder (BPD) have clear evidence of effectiveness: Dialectical Behavior Therapy (DBT), Schema Therapy (ST), Transference Focused Psychotherapy (TFP), Mentalization Based Therapy (MBT), and Good Psychiatric Management (GPM). All are manualized, with published evidence of efficacy. Two additional treatments are Cognitive Behavioral Therapy (CBT) and Alliance Based Intervention for Suicide (ABIS). While the evidence is in conflict about effectiveness for suicide in one (CBT), and not thoroughly studied in the other (ABIS), both are used robustly in a variety of settings and demonstrate promise. A literature review of approaches to the psychotherapy of suicidal patients with borderline personality disorder by members of the Group for the Advanced of Psychiatry Psychotherapy Committee (GAPPC) led to 29 published research and summary reports along with two other reviews of common factors for this group of treatments. Clinicians and/or researchers with experience with each of the therapies reviewed the papers and the treatments and used expert consensus discussions to define common factors. We identified six common factors: 1) negotiation of a specific frame for treatment, 2) recognition and insistence on the patient's responsibilities within the therapy, 3) provision to the therapist of a conceptual framework for understanding and intervening, 4) use of the therapeutic relationship to engage and address suicide, 5) prioritization of suicide as a topic to be actively addressed whenever it emerges, and 6) provision of support for the therapist in the form of supervision, consultation or peer support. Given that many clinicians will treat suicidal patients with BPD, while few will learn even one specific evidence based treatment, we believe that identification of common factors is useful to clinicians and to patients. Awareness of common factors may also improve research, and focus education around work with this challenging group of patients.

VANDERBILT BEHAVIORAL HEALTH POPULATION HEALTH STRATEGY: LESSONS LEARNED FROM AN INTEGRATED, ACADEMIC, STATE WIDE, HEALTHCARE AND DELIVERY SYSTEM
Lecturer: Harsh Trivedi, M.B.A., M.D.

Educational Objective:
At the conclusion of the session the participant should be able to 1) Understand population health as a concept and how Vanderbilt Behavioral Health as applied it for its population 2) Understand the role of quality measures, patient registries, and outcome measures in value based care 3) Understand the role of the psychiatrists in such as system and how to best prepare for the future

Summary:
The Vanderbilt Health Affiliated Network comprises 30+ hospitals, 3,000 physicians, and over 2 million covered lives across Tennessee. Vanderbilt Behavioral Health is tasked with defining and implementing the enterprise wide population health strategy for Vanderbilt University Medical Center. This workshop will illustrate how the population health strategy was developed for behavioral health at Vanderbilt.
There will be a focus on the development of quality measures in psychiatry, the importance of patient registries, and the availability of reliable outcome measures for value based care. The role of such measures in determining reimbursement will be explored as well.
The will also be a focus on electronic health records, the development of healthcare information exchanges, and Vanderbilt's approach to concerns regarding confidentiality and integration.
Last, we will explore the role of psychiatrists in such a system and discuss how to prepare for such roles in the future.

INNOVATIVE PROGRAM

OCTOBER 08, 2015

BREAKING THE CYCLE: EXAMINING RE-ADMISSIONS ACROSS THE CONTINUUM OF CARE

IP 01-1
PSYCHIATRIC RE-ADMISSIONS AT UC SAN DIEGO MEDICAL CENTER: DESCRIBING CHARACTERISTICS OF PATIENTS WITH 30-DAY READMISSIONS
Chair: Lawrence Malak, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the cost and burden of hospital re-admissions and frequent utilization of acute services to the health care system;2) Understand and recognize characteristics and potential risk factors for psychiatric re-admissions;3) Know potential interventions to be used in the emergency room or hospital setting to help reduce recidivism including SBIRT;4) Understand the role of START Programs in the continuum of care within San Diego County Mental Health Care.

SUMMARY:
Psychiatric readmissions reveal possible gaps in our mental health system including access to medications, housing, clinical and substance use treatments. Readmissions also add significant cost and are now used as an outcome measure. This study aimed to describe rates and characteristics of psychiatric patients admitted to UCSD and compare these data with San Diego County Psychiatric Facilities.
Psychiatric admissions to UCSD from 7/1/11 to 6/30/12 were analyzed looking at those with a single admission or no readmissions within 30 days and those with a 30 day readmission. Demographic and clinical characteristics were evaluated in both groups.
825 total admissions with 720 unique patients were analyzed. 83 (11.8%) had readmissions representing 22.8% (188) of total admissions. 42 (5.8%) patients had a total of 101 (12.24%) 30-day admissions. No significant differences were found in Gender, Age or Ethnicity and differences were noted in Insurance status, Cost, Diagnoses and LOS.

IP 01-2
PATIENT-CENTERED RECOVERY PROGRAM: TARGETING PATIENTS WITH CO-OCCURRING DISORDERS TO REDUCE LENGTH OF STAY AND RECIDIVISM TO THE EMERGENCY DEPARTMENT
Chair: Allison Hadley, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the cost and burden of hospital re-admissions and frequent utilization of acute services to the health care system;2) Understand and recognize characteristics and potential risk factors for psychiatric re-admissions;3) Know potential interventions to be used in the emergency room or hospital setting to help reduce recidivism including SBIRT;4) Understand the role of START Programs in the continuum of care within San Diego County Mental Health Care.

SUMMARY:
The UCSD Patient-Centered Recovery Program (UCSD-PCRP) was implemented to address extended length of stay (LOS) in the ED and frequent return visits (recidivism) by the co-occurring disorders (COD) population. UCSD-PCRP aimed to reduce use ED services and increase patient turnover by reducing LOS and recidivism.
UCSD-PCRP used the SBIRT Model (screening, brief intervention, and referral to treatment), an evidence-based intervention for COD patients effective in reducing substance use and increasing use of specialized treatment.
UCSD-PCRP began 11/1/11 with analysis broken down into baseline year before implementation and 3 years after.

7,831 ED psychiatric consults over 3.5 years were included. Average consults per month increased 62.4% in Year 3 (218.1) compared to baseline (134.3). LOS decreased 6.93% in Year 3 (8:44) compared to baseline (9:23). This resulted in return on investment of $170,105. Recidivism increased from 9.8% to 13% in the context of overall increasing consults

IP 01-3
SHORT-TERM ACTUE RESIDENTIAL TREATMENT PROGRAMS:THEIR ROLE AND USE IN THE SAN DIEGO COUNTY CONTINUUM OF PSYCHAITRIC CARE
Chair: Vanessa L. Lauzon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the cost and burden of hospital re-admissions and frequent utilization of acute services to the health care system;2) Understand and recognize characteristics and potential risk factors for psychiatric re-admissions;3) Know potential interventions to be used in the emergency room or hospital setting to help reduce recidivism including SBIRT;4) Understand the role of START Programs in the continuum of care within San Diego County Mental Health Care.

SUMMARY:
Pressure to find cost effective methods of addressing acute psychiatric needs have led to innovative models of care. One model is the Short Term Acute Residential Treatment (START) Programs. START programs began in San Diego in 1980 by the Community Research Foundation and were designed to be community based treatment facilities that serve as an alternative to acute psychiatric hospitalization. The ability of these programs to provide cost effective, voluntary treatment was replicated in various studies and has successfully expanded from a single home with 10 beds to a system of 70+ beds.
The Community Psychiatry Fellowship at UCSD has used the sites for training in a collaborative, community based model. This experience also included Quality Improvement/ Performance Improvement Projects (QI/PIP). One such project looked at admissions to START programs and assessed factors associated with readmissions including demographics, diagnoses, social factors, length of stay and substance use.

HIGH RISK FOR SENIOR CITIZENS

IP 02-1
DEVELOPING A BEHAVIORAL HEALTH GERIATRIC CLINIC FOR OLDER PERSONS EXPERIENCING HOMELESSNESS
Chair: Richard C. Christensen, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have a greater appreciation for the growing population of older persons who are experiencing homelessness in the United States.;2) Have a better understanding of the unique mental health and primary care needs of older persons who are experiencing homelessness, many for the first time in their lives.;3) Discuss the types of interventions utilized in developing and implementing a behavioral health clinic, within the context of a federally qualified health center (FQHC), which is specifically tailored to meet the mental health care needs of older persons who are homeless.

SUMMARY:
The average age of the US homeless population is increasing. Recent studies have estimated that nearly one-third of the homeless population is over the age of 50 compared to only 11% in the 1990's. In our psychiatry clinic , which is part of an integrated, federally qualified health clinic (FQHC) based in Jacksonville, Florida, (The Sulzbacher Center), we discovered that in 2012 over 25 % of our patients were 55 years of age or older. It is well established that geriatric syndromes (e.g., functional impairment, cognitive impairment, visual/hearing impairment frailty, and depression) are all associated with increased mortality and disability. Hence in September, 2013, planning was initiated to develop a psychiatric specialty clinic for older persons (those persons whose age was 55 years or older) who were experiencing homelessness. The intent was to better assess geriatric

syndromes in those we were treating and to provide a tailored treatment approach that took into account the unique recovery needs of aging individuals who were contending with homelessness, many for the first time in their lives.

   This Innovative Program presentation will describe the rationale behind the development, implementation and funding of this specialty clinic which includes psychiatric evaluations and continuity of care, individual psychotherapy, involvement in an age-appropriate Wellness Group and the participation of a peer support specialist who meets with the older person in the development of individual Wellness Recovery Action Plans (WRAP). The presentation will also provide an overview of the numbers of persons served over the past year, the average age, diagnostic diversity and outcomes based upon patient satisfaction surveys and housing stability. At the conclusion of the presentation a "lessons learned" summary will be utilized to stimulate audience participation for a subsequent discussion of future programmatic planning at other clinical sites across the country that provide care to persons experiencing homelessness.

IP 02-2
INTEGRATING PSYCHIATRY AND MEDICINE IN THE CARE OF COGNITIVE IMPAIRMENT
Chair: Lewis Mehl-Madrona, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) identify the role of exercise, diet, cognitive stimulation, and socialization in preventing cognitive decline in minor and major neurocognitive disorder.;2) describe how to treat people with neurocognitive disorders in collaboration with family physicians in the context of group medical visits in which behavioral and medical concerns are combined.;3) describe three practice models for providing integrated psychiatric and medical care for neurocognitive disorders.;4) describe the role of peer counseling and support in changing behavior in the context of neurocognitive disorders.;5) discuss the role of medications and micronutrients in neurocognitive disorders.

SUMMARY:
Large population based studies have revealed the importance of exercise, Mediterranean diet, cognitive stimulation/enhancement, and socialization in delaying the onset of neurocognitive disorders and the transition from minor to major. These factors end up being much more robust and effective that cholinesterase inhibitors, which, while supported by evidence over placebo, have small effect sizes, with numbers to treat approximatng to numbers to harm. The problem with the importance of lifestyle factors is the difficulty people have in changing habits. Geriatric psychiatric consultations rarely lead to any change of behavior. We conducted a pilot study with a group medical visit lasting two hours in which caretakers and caregivers both attended. The group was led by a geriatric psychiatrist, a family nurse practitioner, and a psychotherapist. The group consisted of initial check-in in which patients reported challenges and difficulties and how they overcame them. Then we provided cognitive stimulation/enhancement exercises of graded difficulty, so that everybody completed 30 to 40 percent of the exercises. Then came shared problem solving exercises and socialization. We concluded with mindfulness meditation and movement exercises. Important to the process was the coaching provided within the context of the group medical visit, for patients and caregivers to exercise more, eat better, socialize, and stimulate their brains. We review our preliminary evidence showing the enthusiasm for this approach among patients and its success in a primary care setting. We discuss the impediments to implementing such group medical visits and also billing considerations. Our own pilot study showed that group medical care such as this, generated more income (within the U.S. system) that individual medical visits and was more effective also.

OCTOBER 09, 2015

IMPROVING PERFORMANCE MEASURES: INFUSING THE PREREQUISITE "SPIRIT" NEEDED TO ACHIEVE AND MAINTAIN EXCELLENCE

IP 03-1
IMPROVING QUALITY: THE KEY TO BUILDING HIGH PERFORMING MENTAL HEALTH SYSTEMS
Chair: Nick Kates, M.B.B.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand the dimensions of high quality care and IHIÂ´s Triple Aim;2) To identify where their own service, program or system is underperforming ;3) To use basic QI tools to analyse their service performance and introduce improvements;4) To understand the importance of person and family centred care, and how this can be incorporated into any service;5) To use a simple 8 step model to introduce change in their own system or organisation

SUMMARY:
Increasingly changes in mental health care systems are being driven by the desire to improve the quality, efficiency and safety of the care provided. This workshop will introduce participants to practical tools and approaches for understanding how their system is performing in the 6 domains of quality mental health care â€" patient-centredness, timeliness, effectiveness, efficient, safe and equity â€" that will enable them to identify opportunities for improvement and learning how to implement and sustain needed changes. It summarizes what quality care is, as defined by the National Institute of Medicine, presents an overview of IHIs Triple Aim and discusses where our current systems are underperforming and the reasons why this happens. It outlines a simple 5 step approach for analyzing a system, identifying root causes of problems and introducing improvements and introduces some of the basic tools of quality improvement work that can be used in any setting and describes how they can be used. These include ways to measure team performance: an analysis of how well core processes are working; building a process map; the 5 Whys and the Fishbone diagram to understand root causes; the Improvement model and rapid cycles of change (Plan Do Study Act or PDSA cycles); conducting a supply and demand analysis to improve access; engaging consumers in their own care; and using the consumer / family experience as a way of redesigning services. It then presents the NHS (England) Change model with its 8 components for successful change within a system or organisation, presents ways of changing the culture of an organisation to support innovation and improvement and the impact this can have on outcomes and discusses strategies to sustain and spread these improvements.

IP 03-2
INFUSING 'SPIRIT" INTO A PSYCHIATRIC HEALTH SYSTEM: USING LEAN METHODOLOGY TO ENHANCE A CULTURE OF SAFETY, QUALITY, AND PERFORMANCE EXCELLENCE
Chair: Sunil Khushalani, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to identify how some principles of Lean performance improvement methodology have been applied in a psychiatric healthcare setting.;2) At the conclusion of this session, the participant should be able to recognize how the Plan-Do-Check-Act can be applied to solve complex problems pertaining to safety, quality and service delivery.;3) At the conclusion of this session, the participant should be able to recognize that our daily work is made up of processes, which can be understood, analyzed and redesigned to improve patient care.

SUMMARY:
In 2009, Sheppard Pratt Health System adopted Lean as its preferred performance improvement methodology. The program was named "SPIRIT" (Sheppard Pratt Improvement Resources Inspired by Toyota). Using Plan-Do-Check-Act as its guiding framework, the "SPIRIT" initiative has been rolled out in a tiered fashion - a) daily brief performance improvement huddles which focus at a departmental level, b) rapid performance improvement events at a multi-disciplinary level, and c) a ten-week Lean problem-solving course at a leadership level.
Lean methodology has been making inroads in medical-surgical settings in the last 10 -15 years. However, there are very few psychiatric settings which have applied this methodology in order to transform care and become more patient-centered, outcomes-oriented, and data driven.
What is evident from our experience at Sheppard Pratt is the paradigm shift in the minds of many who have participated in these efforts. Our approach is inculcating a restructured belief that change has to be initiated from within. Recent results suggest that we can all contribute to making psychiatric care delivery more value-added and less wasteful. It is helping us enhance our safety, quality, patient and family satisfaction.

Our workshop intends to share information about these components and the results of our SPIRIT initiative. It is a model for transformative change, which can be adopted by other psychiatric systems of care.

MOVING TOWARD EVIDENCE BASED STANDARDS AND OUTCOMES

IP 04-1
ESTABLISHING STANDARDS OF CARE AND INTEGRATING OUTCOMES MEASUREMENT INTO AN ADULT INTENSIVE OUTPATIENT PROGRAM IN A LARGE COMMUNITY PSYCHIATRY SETTING
Chairs: Michael Van Wert, M.P.H., M.S.W., Anita Everett, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe one treatment model for an intensive outpatient program in a community psychiatry setting.;2) Describe how regular outcomes measurement can be integrated into the daily workflow of an intensive outpatient program.;3) Describe treatment outcomes associated with an intensive outpatient program.

SUMMARY:
Intensive outpatient programs (IOPs) have the potential to be both a clinically and cost effective treatment modality for patients experiencing acute psychiatric symptoms. They are ideal for patients who require more support than traditional outpatient treatment, but less monitoring than inpatient hospitalization. IOPs, however, vary widely in the populations they treat, services offered, admission duration, programmatic structure, setting, and theoretical orientation. In light of this diversity, there is a need to establish best practices for IOPs. Part of creating a standard of care requires integrating regular outcome measurement into the clinical work flow in such a way that these results can be used in a meaningful way to directly inform treatment for individual patients, as well as used for broader IOP program evaluation. We present a description of one IOP model, including its structure and treatment focus, as well as its outcome measurement process, situated within a community mental health clinic. We also present treatment outcome data (depression, anxiety, and stress) from a within-subjects pre-post design for 40 program participants. In sum, the program presented represents a model that can be practically implemented and evaluated.

IP 04-2
MAKING INTEGRATION REAL - OATI: THE CENTER FOR INTEGRATED HEALTH SERVICES ORGANIZATIONAL ASSESSMENT TOOLKIT FOR PH/BH INTEGRATION
Chair: Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand the conceptual framework for how to develop universal PHBH integration capability as a feature of all health and behavioral health programs;2) To learn the elements of the CIHS Organizational Assessment Toolkit for Integration, and how to utilize the tools in a program, agency, organization, or system to improve integrated service delivery.;3) To understand how to implement PHBHI continuous quality improvement activities for any program, related to the following key indicators: access, screening, information sharing, health coaching, disease management, and workforce development.;4) To learn from the experiences of early adopters of the OATI regarding how to best use the toolkit in one's own setting.;5) To learn how to develop a plan for taking next steps to improve PHBHI within base resources in one's own program, agency, organization, or system.

SUMMARY:
CIHS, part of the National Council for Community BH, is the national SAMHSA-HRSA technical assistance center for primary health/behavioral health integration (PHBHI). Based on its early experiences with BH and PH grantee organizations, CIHS recognized the need for programs, organizations, and systems, of any size, structure, and complexity, to be able to develop organized continuous quality improvement (CQI) processes to develop not just a single integrated PH/BH program, or a single "integrated health home", but to develop PH/BH capability throughout the entire organization or system.

Individuals and families with co-occurring PH and BH (including MH, SA, ID/DD, and Brain Injury) conditions are an expectation in all settings, associated with poorer outcomes and higher costs. Best practice approaches for addressing these PH/BH needs in an integrated manner can â€" and should -be developed and applied in any setting, in order to achieve the Triple Aim. However, while most BH and PH organizations have capability to develop individual programs, particularly when there is a specific funding stream to incentivize that, they do not tend to have the ability to engage in organization wide CQI processes that promote improvement for their whole population within base resources.

This toolkit is designed to provide organizations with materials to help them do just that. The purpose of this workshop is to introduce participants to the content of this toolkit and help participants understand how to utilize each element of the toolkit to help make progress in their own organizations.

In early 2012, CIHS engaged ZiaPartners, Inc (Ken Minkoff, MD; Chris Cline, MD, MBA) and MTM Associates (David Lloyd) to develop a comprehensive toolkit for this purpose, building on â€" and expanding â€" the existing tools that had already been developed by each organization. The goal was to create a comprehensive toolkit in the public domain that would be applicable to: primary health providers, mental health, substance abuse, intellectual disability,or brain injury providers, whether working on their own, as partners, or as a collaborative network. This toolkit has been made available for general use during 2014. Dr. Minkoff is the lead author of the toolkit, and has provided training and TA to early adopters.

The toolkit includes: Partnership Checklist; Executive Walkthrough, Administrative Readiness Tool (ART); Clinical Program Self-Assessment (COMPASS-PH/BH); QI Capability Self-Assessment (QI-IQ); Strategic Planning (SPIN); and a Prioritization Matrix. The toolkit also includes a basic framework for PDSA rapid cycle change, and examples of indicators and metrics for seven common areas in which programs or systems might initiate improvement activity.

This workshop will introduce the tools, share some data from early adopters of the toolkit, and provide guidance to participants about how to best use the toolkit in their own settings.

IP 04-3
A NOVEL APPROACH TO MORBIDITY AND MORTALITY ANALYSIS IN PSYCHIATRIC TRAINING
Chair: Tobias D. Wasser, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the value of teaching psychiatry trainees how to recognize systemic influences on adverse outcomes using a root-cause analysis (RCA) framework.;2) Identify the ACGME Psychiatry Milestones which can be fulfilled utilizing such a novel M&M-style conference series;3) Identify ways in which implementing such an M&M-style conference series can identify systemic influences on adverse outcomes or near misses and lead to improvements in patient care.;4) Recognize the need to create a safe, respectful atmosphere to freely discuss errors in order for participants to successfully acquire a sense of agency to improve systemic coordination of care

SUMMARY:
Why don't psychiatrists do Morbidity and Mortality (M&M) conferences, when other medical disciplines have engaged in this practice for decades? There are numerous potential explanations, including the stigma and blaming culture sometimes associated with these forums, the relative rarity of mortality as a result of psychiatric illness, and the difficulty in clearly defining other adverse outcomes in mental health. There is an increasing understanding, however, that paying greater attention to issues of patient safety (PS) and quality improvement (QI) leads to improved patient care, from which psychiatry is not immune. Regulatory bodies which oversee hospitals and graduate medical education have begun to place an ever growing importance on PS and QI. This movement has emphasized not only improving PS via decreasing the number of "medical errors" but also using QI to actually improve clinical care through assessment and systems-level changes at healthcare institutions. The ACGME has identified this as integral to residency education, including proficiency in QI and PS in the developmental Milestones residency training directors must use to assess resident proficiency and advancement during training. One opportunity to utilize QI is via systematic and structured reflection on the quality of clinical care. Ideally, M&M conferences provide timely and structured peer review, prompt reporting, analysis of adverse events, and education on the latest evidence-based practice. Toward this end, we initiated a trainee-led M&M-

style conference series for the mental health service line of the VA associated with our institution (1). The success of the series has led to its expansion and implementation at our institution's community mental health center. The series was established to create a safe, interdisciplinary forum for the structured discussion of unfavorable outcomes and near-misses utilizing a root-cause analysis (RCA) framework. The focus of the sessions has been on analyzing any need for revision of policy, reallocation of resources, further education of staff/trainees, etc. that might enhance timely and optimum care. Also central to these forums is a true interdisciplinary discussion with representation from all shareholders who might have a stake in institutional changes. In our presentation, we plan to present the frame for our novel M&M-style conference series, outline its success to date, and discuss how similar initiatives could be implemented at other institutions. We then plan to demonstrate the ease and utility of the model by having participants engage in an interactive workshop in which they utilize the frame to analyze systemic influences on the outcome of a real case provided by the presenters.

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OCT 10, 2015

IMPLEMENTING EVIDENCE BASED TREATMENT MODELS

-1
COGNITIVE BEHAVIOR THERAPY: INTRODUCING EVIDENCE BASED TREATMENT TO A CLINICAL SERVICE
Chair: Dianna Dragatsi, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1)   Identify evidence based psychotherapies for people with severe mental illness in community settings;2)   Identify gaps in provision of evidence based psychotherapy in clinical settings such as the Washington Heights Community Service and how it applies to their own clinical practice;3)   Describe an innovative model for teaching an evidence based psychotherapy incorporating both lectures and a simulated patient actor;4) Learn how to implement the practice of evidence based psychotherapy for chronically mentally ill patients

SUMMARY:
In this workshop, we will begin by introducing evidence based psychotherapies promoted in the literature for people with severe mental illness. These include Cognitive Remediation and Cognitive Behavior Therapy. With this information as a background, we will describe the gaps in the provision of these evidence based psychotherapies in clinical settings. We will describe an innovative program for teaching an evidence based psychotherapy, Cognitive Behavior Therapy, and discuss how we implemented this program on the Washington Heights Community Service, on both its inpatient and outpatient units. The utilization of a simulated patient actor facilitates consolidation of new therapy skills. The classes and practicums are performed in interdisciplinary small groups, that is, psychiatrists, psychologists, nurses, occupational therapists, employment specialists and social workers from 3 clinics and an inpatient unit. This setting further enhances communication, collegiality among interdisciplinary staff. We will show how we go beyond teaching, to ensuring clinicians can confidently provide evidence based treatment in their daily practice.

-2
ADAPTATION OF THE DBT CONSULTATION TEAM MODEL IN A HOSPITAL BASED CLINIC SETTING TO ENHANCE PATIENT CARE AND RAISE STAFF MORALE
Chairs: Helen Kim, Ph.D., Jerome H. Kogan, Psy.D., Joshua Dorsky, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) 1) understand the basic tenets of the Dialectical Behavior Therapy (DBT) Consultation Team model and ;2) 2) recognize how this model was adapted to

be utilized within a hospital based clinic generalist staff environment and ;3) 3) identify DIPS/High Risk as a potential tool that can enhance the quality of clinical care, help manage high-risk cases, reduce staff burnout/heighten morale, and encourage staff development.

SUMMARY:
DBT has emerged as one of the most exciting developments to arise in the world of psychotherapy in recent decades. A key component of DBT is the notion that the therapist working with demanding, high-risk, and vulnerable patients must herself be supported to meet their needs without burning out or feeling helpless in the process. Additional goals of the DBT Consultation Team are to track adherence to DBT standards and to enhance delivery of fully competent clinical care. At our clinic our objectives were to improve our management of high-risk patients, boost clinician morale, enhance communication within treatment teams, and to promote commitment to excellence in delivery of clinical care. We liked the DBT Consultation Team model and asked if we could introduce such a model to a mostly generalist staff that had mixed levels of exposure to DBT.
We will present and discuss the course of such an implementation at our hospital based clinic in the form of a weekly clinical meeting which we named DIPS/HR (DBT-Informed Peer Supervision/High-Risk). DIPS/HR is a multi-purpose group adapted from the DBT Consultation Team model. DIPS/HR is attended by all clinical providers at our site, both staff and trainees. Although DIPS/HR is modeled after Marsha Linehan's DBT Consultation Team. our clinic is mainly a generalist trained staff with only a small core of fully-trained DBT staff. We are not a DBT clinic and do not represent ourselves as such. We do not represent to our patients that they are receiving DBT treatment to distinguish any of our DBT-informed practices from comprehensive DBT conducted by fully-trained providers. Within the scope of these clearly delineated limits, we have seen positive effects of introducing DIPS/HR. In addition to benefits in the areas of enhanced clinical care delivery and staff satisfaction, DIPS/HR is serving as a valuable training component for our trainees of all disciplines (psychiatry residents, psychology interns and externs, social work intern) as well as providing an opportunity for staff and trainees to mingle together on a weekly basis.
In analyzing the contributors to our success in adapting a DBT component to our setting, we have identified the following factors: 1) the efficacy of the DBT Consultation Team model itself 2) unequivocal support for DIPS/HR from the clinic leadership ranks 3) a pro-DBT attitude on the part of the general staff 4) presence of a fully-trained DBT staff member serving as a DBT mentor and leader providing an in-service didactic series on DBT basics attended by all clinicians.

PEER SUPPORT SPECIALISTS: IMPROVING THE PARTICIPATION OF PATIENTS IN THEIR TREATMENT

IP 06-1
OPENING DOORS TO RECOVERY: AN INNOVATIVE APPROACH FOR COMMUNITY NAVIGATION SPECIALISTS WORKING WITH INDIVIDUALS WITH SERIOUS MENTAL ILLNESS
Chairs: Samantha Ellis, B.A., Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the Opening Doors to Recovery (ODR) Model and its critical role in helping individuals with serious mental illness (SMI) to reduce the cycle of institutional recidivism and embrace recovery;2) Define the roles of the three Community Navigation Specialists (CNSs): the Professional CNS, the Peer CNS, and the Family CNS ;3) List two community support components of ODR

SUMMARY:
SUMMARY: Individuals with serious mental illnesses (SMI) and a history of psychiatric hospitalization are often caught in a cycle of institutional recidivism, including repeated hospitalizations, incarcerations, homelessness and lack of personal recovery. These problems are exacerbated by inaccessible community services; unengaged local stakeholders who could be partners in community support; and poor communication between mental health and the police. The Opening Doors to Recovery (ODR) model was developed in order to help individuals with SMI break this cycle and facilitate recovery. ODR assists participants by providing them with a support team comprised of three Community Navigation Specialists (CNSs): a licensed social worker (the "Professional CNS"), a

peer specialist with lived experience (the "Peer CNS"), and a family member of someone with SMI (the "Family CNS"). This support team assists in community navigation (by mapping all available resources) and is embedded within the local community. In addition, they also provide recovery support by focusing on: (1) ensuring adequate treatment, (2) maintaining safe housing, (3) developing a meaningful day, and (4) using technology to support recovery. At least two other features of ODR differentiate it from other community-based services: a group of collaborative local partners committed to supporting ODR and the work of the CNSs, and a linkage system with the police which alerts the CNSs when one of the participants has an encounter with local law enforcement. These components of ODR work together in order to decrease institutional recidivism and promote recovery.

IP 06-2
PROJECT ENGAGE: USING HOSPITAL-BASED PEER NAVIGATORS TO ENGAGE MEDICAL INPATIENTS SUFFERING FROM SUBSTANCE USE DISORDERS
Chairs: Manish Sapra, M.D., Terry Horton, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize benefits and challenges of services delivered by peers in hospital based setting;2) Recognize incidence of substance use disorders in medical inpatients and its effect on utilization of medical care;3) Learn and discuss strategies to motivate hospital inpatients to initiate and adhere to substance use disorder treatment

SUMMARY:
Patients with untreated substance use disorders (SUDs) are at risk for healthcare overutilization. Project Engage at Christiana Care Health Services in Delaware was developed to facilitate entry of these patients into SUD treatment. Inpatients on the medical service with SUDS received bedside assessment with motivational interviewing and facilitated referral to treatment by a Peer Counselor working in concert with a social worker. Program outcomes demonstrate enhanced admission into SUD treatment with reduction in 30-day readmissions, healthcare utilization and costs. Encouraged by these findings, several insurers and the Pennsylvania Department of Public Welfare are funding a similar pilot within three community hospitals at the University of Pittsburgh Medical Center (UPMC). The purpose of this presentation is to introduce the audience to elements of this innovative model, outcomes and lessons learned.

ENGAGING LAW ENFORCEMENT IN AN OPEN DIALOGUE: SUPPORTING COLLABORATION WITH MENTAL HEALTH

IP 07-1
AN INNOVATIVE ELECTRONIC LINKAGE SYSTEM TO CONNECT LOCAL LAW ENFORCEMENT TO MENTAL HEALTH
Chairs: Simone L. Anderson, B.S., Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss how the fragmentation between mental health and criminal justice systems leads to major clinical and public health burden for adults with serious mental illness ;2) Describe how the police-mental health linkage system works ;3) Identify the components necessary for implementation in other community health settings

SUMMARY:
SUMMARY: Many adults with serious mental illness, who are currently in correctional supervision as well as those who interface frequently with the police, are continuously shifting between homelessness, medical institutions, and the correctional system with high social and fiscal costs to society. This cycle can cause serious negative consequences for the individuals as homelessness or incarceration increases the risk of the other. Many detainees are released to homelessness resulting from their loss of employment, entitlements, or stable housing during incarceration. Mental healthâ€"criminal justice fragmentation delays treatment, and consequently exacerbates chronic illnesses. Thus, as pre-arrest/pre-booking is the first and most effective stage within the correctional

system for interception, our new intervention focuses on this level, during the actual officer–patient encounter. Study participants, who are individuals with a serious mental illness and a history of law enforcement contact, are registered into a special state law enforcement database. When participants come into contact with law enforcement and a background check is run, a prompt alerts officers to contact the linkage specialist. The linkage specialist is a licensed professional who can share information about the participant's diagnosis and treatment and assist the officer in finding alternatives to arrest, when appropriate. Our innovative systems linkage approach, or a pre-booking jail diversion approach, aims to minimize the fragmentation of services and the potential criminalization of people diagnosed with mental illnesses.

IP 07-2
MENTAL HEALTH AND LAW ENFORCEMENT: IMPLEMENTING A VA POLICE BEHAVIORAL STRATEGIES COURSE
Chair: Alauna Davis Curry, B.Sc., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) 1) identify the educational needs of VA Law Enforcement related to Mental Health; ;2) 2) recognize the challenges of implementing a VA-wide training of Law Enforcement Personnel; ;3) 3) learn about an innovative model of delivery of behavioral strategies training curriculum to VA police forces and ;4) 4) understand the importance of improving collaborative and positive interaction between Mental Health and Law Enforcement in general.

SUMMARY:
There are approximately 3200 Law Enforcement Officers serving in the Department of Veterans Affairs (VA). As new generations of veterans are rapidly entering the VA healthcare system as patients, the number and scope of law enforcement is also increasing. A quick glimpse at current events highlights the importance of police forces receiving specialized training in how to interact with individuals who may be exhibiting signs of emotional distress. Crisis Intervention Training (CIT) is available in many jurisdictions; however it is not required for every police officer, with many departments creating specially trained teams to be called out to specific incidents. Therefore, beyond basic police academy training, this leaves a great number of officers with minimal training in how to engage an emotionally distressed person and help to create a positive outcome. To address this knowledge gap, several entities within the Department of Veterans Affairs Mental Health partnered to produce a Behavioral Strategies Training Course to be disseminated to all VA officers. The goal of the Course is to provide support for Officers in addressing problematic behaviors, improve verbal and de-escalation skills for low risk situations, and aid in recognition of where mental health symptoms may inform their intervention responses. A secondary benefit of such training is improving the relationship between mental health and law enforcement personnel, thereby helping to link veterans to mental health services and potentially diverting them from negative legal interactions. This presentation will highlight the challenges of disseminating this national program in our local VA setting and highlight key curriculum components the officers received. This innovative program workshop will emphasize the important and underutilized role of mental health providers as educators and advocates for the mental health population by being an informed and objective liaison for law enforcement entities.

IP 07-3
LAW ENFORCEMENT INVOLVEMENT WITH PATIENTS ADMITTED TO INPATIENT PSYCHIATRIC UNITS: THE PRACTICE AT BELLEVUE HOSPITAL CENTER
Chair: Jeremy Colley, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To identify occurrences on inpatient psychiatric units which may lead to criminal charges against a patient.;2) To identify the legal justifications for pressing criminal charges;3) To learn the clincal, legal and ethical implications of pressing charges against a psychiatric inpatient;4) To learn how hospital leadership can provide support, education and consultation to members of the hospital community who are considering filing charges against a psychiatric inpatient

SUMMARY:
Bellevue Hospital Center has developed written policies to help patients and staff make informed decisions when considering whether or not to press charges against a psychiatric inpatient, who has alleged engaged in criminal conduct while admitted to the hospital. Typically, patients and staff may consider pressing charges when another patient engages in violence towards others or destruction of property. At Bellevue, when a member of the hospital community is considering pressing charges against a psychiatrist inpatient, a consultation team responds. This team consists of the director of forensic psychiatry, the director of hospital police, the director of nursing, the director of inpatient psychiatry, the director of quality assurance and the director of hospital adminstration. The committee reviews the events surrounding the alleged offense, educates the person how is considering pressing charges regarding his rights, the legal justifications for pressing criminal charges, in general, and the probable consequences legally and clinically of pressing charges, or not. This presentation will review the policy and procedure at Bellevue and present data regarding its effects on rates and situations leading to arrest since it implementation.

THE VALUE OF THE RECOVERY MODEL: THE EMPOWERMENT INHERENT IN THE DEVELOPMENT OF SPECIFIC PROGRAMS

IP 08-1
CREATING A RECOVERY BASED SYSTEM OF CARE AT MHALA: PROGRAM COORDINATION, PATIENT FLOW, AND LEVEL OF CARE TOOLS
Chair: Mark Ragins, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To conceptualize how an entire system of care can be built matching the person's level of recovery rather than the severity or type of their illness using the Milestones of Recovery Scale (MORS);2) To identify the differentiation needed in each of the comprehensive services being offered by each program to meet the person where they are in their recovery.;3) To understand the personal, program culture, and relationship issues involved in implementing patient graduation and flow through a system of care;4) To understand the triage and outcome measure tools that we've developed to support a managed care infrastructure for a case rated, recovery based system of care

SUMMARY:
MHALA has expanded upon our Village program, an exemplary, IPS Gold Medal award winning, recovery-based program to create an entire recovery based system of care.
Building upon the Milestones of Recovery Scale (MORS) stages of recovery (unengaged, engaged but poorly self coordinating, and self responsible) we have created programs that meet people's needs specifically where they are in the recovery process rather than basing services on the severity or type of illness they have. This array of programs includes a Homeless Assistance Program, several "housing first" programs, a Welcoming Team, Homeless Innovations Program (a street outreach, integrated medical, substance abuse, and mental health care team), a Transitional Aged Youth Academy, three long term Full Service Partnership "neighborhood teams", a less intensive Field Capable Clinical Services "Village Horizon Services" Team, and a Wellness Center. Each level includes comprehensive services delivered in stage of recovery specific ways including medications, housing, employment, education, money management, crisis management, community integration, substance abuse services, and medical care. All programs are person-centered, goal directed, client-driven, and strengths based. With "no wrong door" and multiple entrances, the ability to move "backwards" if needed, an internal navigator / "concierge", and intentional "graduation" and "flow" between the various individual programs we've facilitated movement throughout the system. We've addressed the significant challenges for both staff and the people we serve of wanting to hold on to familiar relationships rather than moving on and created a pervasive culture promoting recovery and flow. People learn along the way to focus upon their internal strengths and growth rather than dependency on a particular staff because they're going to be moving on. They get stronger at relationship transitions while having access to a large community of people who know them. Staff work in the level most suited to their skills and gifts.

We track people's movement throughout the system, their quality of life outcomes, and our discharges. To supplement the MORS we have created a Determinants of Care tool that tracks each person's self-coordination skills and their need for intensive case management support. We usually have no waiting lists for our programs because people move forwards opening up slots for more people.

We presently are funded by a hybrid of case rated and fee-for- service funding, but we're poised to become a multilevel, managed care system with several service packages and case rates depending on the person's level of recovery and self coordination.

IP 08-2
PROMOTING A HEARING VOICES NETWORK IN A COMMUNITY MENTAL HEALTH CENTER
Chairs: Lauren A. Utter, Psy.D., Tom Styron, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to identify at least 5 steps that are frequently involved in establishing a HVN Support Group in inpatient and outpatient settings.;2) Participants should be able to describe the philosophical approach of the Hearing Voices Network (HVN), including 3 ways that the HVN may be helpful to individuals who hear voices, see visions, and/or other unusual sensory experiences.;3) Participants should be able to identify 4 considerations for training and educating staff and peers about the HVN approach within a community mental health center.;4) Participants should be able to recognize at least 3 challenges that may emerge in establishing a HVN Support Group in a clinical setting.

SUMMARY:
For more than 25 years, The Hearing Voices Network (HVN), which originated in Holland, has helped provide alternative points of view and support for individuals who hear, see, or sense things many other people do not. Hearing Voices Support Groups based on HVN principles are the most recognized approach. There is growing, primarily anecdotal, evidence that these groups are highly beneficial. Purported benefits include increased hope, acceptance, sense of community, and strengthened coping skills. Notably, voice hearers are encouraged to interact with their voices and to begin to understand the relationship between their voices and life experiences. The Network has grown in the U.S. and there are now over 50 U.S.-based support groups. Connecticut is the first state to create its own HVN, offering Hearing Voices Groups Facilitator trainings, forming a board of trustees, and increasing statewide recognition of the HVN among peer advocacy groups, LMHA's, and institutional bodies such as Yale University.
Two professional allies of the HVN, one of whom is a trained HVN Group Facilitator, will offer guidance on introducing the HVN into public sector mental health. Their reflections are based on their personal experiences with introducing the HVN at the Connecticut Mental Health Center, an urban, community mental health center, owned by the State and operated by DMHAS in partnership with the Yale Department of Psychiatry. Successes and barriers in familiarizing staff and consumers with principles of the HVN through education and training, as well as establishing support groups within CMHC will be elucidated. Potential challenges to introducing the HVN in a clinical setting, such as issues of confidentiality will be discussed. Finally, unique considerations for introducing the HVN in inpatient and outpatient settings will be identified.

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IP 08-3
PATHWAYS TO INDEPENDENCE: AN INNOVATIVE SERVICE FOR ADULTS EXPERIENCING CHRONIC HOMELESSNESS
Chairs: Jeanne Steiner, D.O., Michael Rowe, Ph.D., Molly Brown, Ph.D., Allison N. Ponce, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the unique service needs of adults who experience chronic homelessness.;2) Understand stakeholders' perceptions of specialized, focused, recovery-oriented services to increase housing placements, income, and improved engagement in medical and mental health care. ;3) Recognize the relationship between program outcomes and service recipients' perceptions of their citizenship in the community.

SUMMARY:
Individuals experiencing chronic homelessness have significant service needs for attaining housing, income, and wellness. Most often, case managers serve as the primary source of service connections and must possess a breadth of knowledge to direct clients to the services best suited to meet their needs. However, due to large caseloads, case managers often lack resources to provide more specialized, intensive services. In order to address the limitations of the generalist case management model, a large homeless service provider in New Haven, CT implemented the SAMHSA-funded Pathways to Independence (PTI) program. PTI offered a menu of services to foster community independence among individuals who were chronically homeless, including supported employment; SSI/SSDI Outreach, Access, and Recovery (SOAR); peer support; medical service navigation support; and housing referrals. Eligible clients were assigned to one or more support services based upon individual needs, and each service was provided by a staff specialist. This symposium will describe both implementation and outcome-related findings from the evaluation of PTI to provide a comprehensive description of the benefits and challenges associated with this innovative program. Presenters will discuss results from focus groups with key stakeholders. Qualitative themes revealed among program clients and staff highlight several unique aspects of PTI, such as staff specialization and a focus on individualized services. Given PTI's focus on person-centered services, wellness and recovery-oriented outcomes were assessed. As such, the presenters will report on changes in PTI participants' self-assessed citizenship after engagement in the program and will discuss these findings in the context of previous research on citizenship among individuals diagnosed with mental illness. Finally, the presenters will report on the 6-month outcomes of PTI. Consistent with program goals of reducing homelessness, 74% of program participants obtained housing through participation in the program. However, given this program did not have housing subsidies attached, the SOAR and employment program components fostered these housing outcomes, as 28% of those housed were residing in mainstream housing.

OCT 11, 2015

THE PURSUIT OF WELLNESS AND ITS IMPLEMENTATION

IP 09-1
STEPPING INTO WELLNESS: PEER HEALTH NAVIGATION IN AN INTEGRATED PRIMARY CARE CLINIC

Chairs: Rebecca Miller, Ph.D., Chyrell D. Bellamy, M.S.W., Ph.D., Emily M. Recalde, B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the training needs and strategies for peer health navigators in an integrated primary care setting;2) Understand key practices in health navigation for people with serious mental illness;3)   Learn more about an integrated care model within a community mental health center

SUMMARY:
Since the 2006 report showing that people with serious mental illness die 25 years earlier than the general population, a new focus on healthcare for people with SMI, particularly integrated physical and behavioral healthcare. The Primary and Behavioral Health Care Integration (PBHCI) grants (SAMHSA) have enrolled over 40,000 people in integrated care programs across the country. One of the innovative aspects of these programs is the use of peer support within these settings. This presentation will describe a PBHCI grantee's experience training and deploying Peer Health Navigators in an integrated primary care clinic co-located within a community mental health center.

Peer support is considered a best practice in mental health, with those with lived experience able to engage and provide role modeling to others with behavioral health conditions (Davidson et al., 2012). Recently this model has been expanded to a role working as a Peer Health Navigator (Swarbrick, 2013), a non-medical professional who assists in guiding someone with a health condition through the health care and social service systems. Peer Health Navigators are people with their own lived experience of recovery from mental health and/or substance use who play a unique role in motivating, educating, and supporting people in achieving individualized health and wellness goals in part by sharing their personal experiences of recovery.

In this program, we will outline the training and development of the role within the clinic setting. A Peer Health Navigator will share experiences and successes and challenges of the role, and relate it to the broader initiative nation-wide of promoting integrated care.
collaborate with clinicians to develop supportive relationships between you and the wellness center.

IP 09-2
PROMOTING VOTING RIGHTS AND REGISTRATION AMONG INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES
Chair: Tom Styron, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) By the conclusion of this presentation, the audience will have an understanding of the Voting Rights Act of 1993, its legal requirements and other implications as they relate to all public mental health centers and individuals with SMI.;2) By the conclusion of this presentation, the audience will have an appreciation of challenges related to enhancing voter registration within public mental health centers and for individuals with SMI.;3) By the conclusion of this presentation, the audience will possess practical information as it relates to strategies and opportunities to enhance voter registration for individuals with SMI and their importance to recovery-oriented care and citizenship

SUMMARY:
Voting is a citizenship right, yet voter registration rates are historically and currently low for persons with disabilities, a condition that persists even after the passage of the Voting Rights Act of 1993, which mandates that state or local government offices provide voter registration assistance to new applicants for services. This presentation concerns voter registration activities at a large public mental heath center in a New England city from 2012 to the present. Presenters will: (1) provide a contextual overview of voter registration and voting activity among persons with psychiatric disabilities, (2) locate voter registration activities in the context of an applied theoretical framework of citizenship involving the 5 Rs of rights, responsibilities, roles, resources, and relationships as a means of supporting the community inclusion and valued participation of persons with

psychiatric disabilities, (3) provide a case description of iterative efforts including a time-limited voter registration campaign, identification of registration-related issues for clients including lack of photo IDs, and successful efforts to add voter registration to client intake at the mental health center, (4) review barriers to and opportunities for enhancing voter registration in public mental health settings and (5) provide to local and mental health authorities and mental health centers and clinics recommendations for enhancing voter registration activities, while arguing that doing so enhances the promise of community mental health care not only to provide effective treatment, but to support "a life in the community" for persons with psychiatric disabilities.

RECOVERY: THE IMPORTANCE OF RECOGNIZING HOW IT IMPACTS THE MENTAL HEALTH SYSTEM

IP 10-1
RECOVERY IN ACTION: PROMOTING CULTURE CHANGE THROUGH RECOVERY STORIES
Chairs: Rebecca Miller, Ph.D., Elizabeth Lobotsky, B.A., David Howe, L.C.S.W., Thomas H. Styron, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the value of personal stories of recovery in changing an organizational culture ;2) Identify the elements of an orientation program for staff utilized to promote culture change;3) Identify 3 elements of recovery-oriented care as it relates to community mental health settings

SUMMARY:
Narrative and recovery stories provide an important vehicle for culture change (Borg & Kristiansen, 2004), particularly in promoting values of recovery including hope and respect (SAMHSA, 2012). This program describes the work being done at the Connecticut Mental Health Center in promoting a recovery-oriented culture, specifically the use of recovery stories promoted during staff orientation and training to increase connection to recovery principles and values. As a way of introducing recovery-oriented care, people in recovery are invited to serve as expert panelists at the new staff orientation and seminars or trainings. The panel members share what works and what hinders recovery, and staff are invited to engage and participate. As a training facility for psychiatric residents, psychology fellows, nursing students and others, there is a chance to influence practice both within the local CMHC and beyond, as these trainees go on to work in systems of care across the country. This program describes the structure of the panel discussion, the facilitator's role and responsibilities, and preparation of panel members. During the program, one of our staff will present a sample excerpt of a panel discussion drawing on a recovery story. We will present initial evaluation results showing the impact of the program on staff and trainees' views.

IP 10-2
LOCAL MENTAL HEALTH COUNCIL: A NATIONAL POLICY FOR A MULTI-SECTORAL COLLABORATION TO IDENTIFY AND HELP PEOPLE WITH MENTAL ILLNESS
Chairs: Andrea Tortelli, M.D., Pilar Arcella-Giraux, M.D., Anne Guilberteau

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) enable community (professional and non-professional) participation and decision making in the planning and the provision of mental health care systems.;2) develop a network on prevention of crise situations in the community and better collaboration in intensive case management;3) identify barriers to mental health care services in vulnerable populations (migrants, homeless people) ;4) work on a convention (charter) to protect rights of service users

SUMMARY:
Introduction:
The local mental health council is part of the national mental health policy since the 70s. It is a permanent, local, multi-disciplinary network including mental health services, local authorities, social workers, housing managers, general hospital, peer support services, service users, etc. It facilitates the exchange and the collaboration in the aim to improve the quality of life of people with mental health problems. It helps in the identification of needs for

this population.The local mental health council of the 20th district of Paris identified in the last year that the priority to be worked on was to support people with mental health problems living (most of time alone) in public housings

Objectives:
- identify resources and specify pathways to care;
- collaborate to each other on the identification of people with mental health problems and their needs;
- work on prevention and management of crisis
- to fight against stigma.

Methods:
- A multi-disciplinary group participate to 10, monthly workshops including information, theory and exchange on situations. Themes are chosen based on their own suggestions
- A target group for housing attendants will work on sensitization on mental health issues and management of emergency related to mental health problems.
- The quality and the impact of the workshops and target groups are evaluated.The number, type and the outcome of the situations managed by the network will be analyzed

Results
- Creation of a local guide (catchment area) on mental health and housing including information on local resources by theme, based on the workshops - Creation of a booklet for housing attendants to manage emergency related to mental health problems. - Creation of a local, permanent, multi-disciplinary board supported by the mayor of the district to ensure the efficacy of the network on mental health and housing

Conclusions
Mental health problems may result on disempower, but community based mental health care can play a central role in enabling people to keep recovery

IP 10-3
HUMOR BASED INTERVENTIONS IN MENTAL HEALTHCARE: FROM PRE-HISTORY TO THE 21ST CENTURY
Chair: Miguel M. Alampay, J.D., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the role of humor as a means of comfort and interpersonal relatedness throughout history.;2) Recognize the use of humor as a medium of developing rapport with patients resistant to mental health treatment ;3) Understand humor as an intervention with a demonstrated biological basis and growing evidence base for the treatment of disorders commonly seen in primary mental health care;4) Identify the use of humor modalities as minimal-cost adjuncts that can be culturally tailored to specific populations without risk of medication interactions and delivered by providers at various levels to training.

SUMMARY:
This workshop introduces participants to the role humor, one of the oldest forms of therapy, has played in human interaction from early human experience to present day. Beyond providing a sociological and historical background of humor as an element incidental to human interaction; providers demonstrate the role humor as a means of developing, promotomg and bolstering resiliency; as well as survey the growing wealth of evidence that humor itself can be an agent of positive physiological and psychological change. We draw on sources ranging from the Qi Gong Laughing Program in Taiwanese adolescents, to the growing gerontology literature to our experience with improvisational group therapy for active duty military service members.

The presenters demonstrate the success of specific humor-based interventions (HBI) in improving patients' quality of life and overall functionality in a variety of settings. These gains have been particularly meaningful in populations where the marginal risk of additional medications is greater, where behavioral health stigma persists

despite significant efforts to encourage the seeking of care, or where access to advanced level mental health training is constrained.   Additionally, we show that HBI can be used as a means of training and preventing burn out amongst providers themselves.

Many of the presented approaches to integrating humor involve minimal formal training and are designed to ultimately be autogenic. Accordingly, we show that these interventions can be taught to, and delivered by, providers of various levels of training (nurses, psychiatry technicians, social workers) and yield demonstrable benefits. Adopting these modalities can therefore promote more efficient triage of care, especially when delivered in the group setting, in a manner more appealing to both providers and patients â€" both of which report benefiting from this means of therapeutic interaction.

Chair: Stevan M. Weine, M.D.
Presenters: Peter Gottschalk, Ph.D., M. Saud Anwar, M.D., M.P.H., Stevan M. Weine, M.D., Aliya Saeed, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the terms radicalization, extremism and violent extremism; 2) Identify the concepts and existing models of CVE programs, their potential, as well as challenges.; 3) Identify potential avenues for empowering Muslim communities, including using public health approaches.; 4) Identify ways of integrating mental health approaches into CVE.

SUMMARY:
Countering violent extremism (CVE) has arrived. CVE is an array of policies, programs, and initiatives designed to both prevent violent ideologies from taking hold of people in the first place, and to stop them from crossing the line towards actual violence. It is now a top U.S. governmental domestic and global strategy for addressing the evolving threat of violent extremism. Current domestic CVE strategy is rooted in the 2011 White House Strategic Implementation Plan, with recent precedents in the U.K. Prevent program and the LAPD's Muslim Liaison Unit. The American Muslim community is growing in it's numbers, influence and maturity. Empowering the Muslim community to resist violent extremism requires cultural competence, identification of strengths as well as vulnerabilities in the community is a requisite for any sound CVE program. CVE theory and models, best practices, and evidence of effectiveness are emerging fields .Several questions are in urgent need of clarification: How are CVE programs being developed and adapted in diverse domestic and international settings? How can legitimacy with, trust in, and cooperation from the public in law enforcement and government be enhanced through CVE? How can law enforcement and government conduct traditional policing and security operations when needed without undoing trust, legitimacy, and cooperation gained by CVE and community policing approaches? What role can mental health play in CVE? Can community policing practices geared towards other communities be adapted to serve the Muslim community's need to keep violent extremism at bay? If CVE is to be effective and sustainable, then these questions, among others urgently need answers. This presentation was organized by the Committee of Terrorism and Political Violence of the Group for Advancement of Psychiatry. It includes psychiatrists, community members, and multidisciplinary academics.

OWNING THE GAP: THE PSYCHIATRISTS' ROLE IN REDUCING MORTALITY: TIME TO "OWN THE GAP"
Chair: Lori E. Raney, M.D.
Presenters: Lori E. Raney, M.D., Benjamin G. Druss, M.D., Joseph J. Parks, M.D., John S. Kern, M.D.

SUMMARY:
There has been significant interest in the health disparity for patients with behavioral health disorders for the past decade, especially since the publication of the NASMHPD report in 2006. However, it is unclear if the mortality gap is decreasing in spite of programs that have been implemented by SAMHSA and CMS with funding from the Affordable Care Act. Where is the psychiatrists' responsibility in closing the gap and how can we use our training in both general medicine and the specialty of psychiatry to improve the health of our patients? This Forum aims to describe programs that are going on across the nation and seek answers to this important question.

OCTOBER 11, 2015

COLLEGE MENTAL HEALTH: ROLES, LEADERSHIP, CHALLENGES AND OPPORTUNITIES
Chair: Michelle Riba, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review the challenges of providing clinical services in college mental health; 2) Discuss some of the training opportunities and challenges; 3) Review some of the leadership and staffing issues in developing and building college mental health services.

SUMMARY:

College students are a growing and important population in need of evidence-based mental health services (Kirsch, Pinder-Amaker, et al 2014). While the majority of students are young adults, there is a wide range, especially in community colleges, online programs, and older adults seeking degrees and additional training, and those returning from military service. Campuses may be rural or urban, large or small, private or public and the students may be attending with chronic psychiatric or other medical problems, have particular needs as student's athletes, or be coming from countries far away, and the student with few psychosocial supports.

With this growing group of diverse students, a day hardly goes by without the media alerting us to some tragedy of a student who suicides, or is bullied, or a campus where there is violence, or a new trend emerging , such as helicopter parents , or the role of social media playing a role in some aspect of campus life.

As clinicians, our roles and responsibilities are changing. Many college mental health services are seeing a rise in students going on websites and asking for help or looking for resources; campus programs are trying to determine if they have the right and numbers of clinicians to provide services that students and their families are requesting; and psychiatry departments are seeking ways to increase training of medical students and residents in this important area of need.

This forum will ask participants to review topics of concern and problem solve how to think about organizing and providing care to a growing number of students who are seeking clinical services. The college mental health service, with its multidisciplinary staff and faculty, might be considered the new community mental health center for large numbers of students, and a growing need for us to better understand and for which we need to provide services.