

175 YEARS of APA

1844 / 2019

Syllabus & Proceedings

AMERICAN
PSYCHIATRIC
ASSOCIATION
ANNUAL MEETING
May 18-22, 2019 • San Francisco



APA Publishing Sessions

Saturday, May 18, 2019

Autism Spectrum Disorder: Essentials of Cutting-Edge and Evidence-Based Treatments

Chair: Eric Hollander, M.D.

Presenters: Casara J. Ferretti, M.S., Randi Hagerman, M.D., Robert Lee Hendren, D.O., Asif M. Rahman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Highlight the role of the psychiatrist in the optimal assessment and treatment of ASD; 2) Describe the cognitive assessment of infants and toddlers with ASD, and to describe patients with optimal outcomes; 3) Elucidate how symptoms overlap between ASD and obsessive compulsive personality disorder and OCD related disorders; 4) Discuss new targeted treatments for fragile-X syndrome and syndromal ASD based on molecular mechanisms; and 5) Review new data and procedures on transcranial magnetic stimulation treatment in ASD

SUMMARY:

Autism Spectrum Disorders (ASD) are common and complex neurodevelopmental disorders which may present at different stages with diverse target symptoms (Hollander E, Fein D, Hagerman R, 2018). This symposium will help educate the psychiatrist to optimally participate in the assessment and treatment of ASD. It will raise awareness and expertise in both the practical management of ASD and new cutting edge treatments. A review of evidence based treatments for various target symptoms of ASD will be presented (Hollander E, Kolevzon A, Coyle J,, 2011). The role of comorbidity in treatment selection will be highlighted. Comprehensive cognitive assessment of infants and toddlers will be described, and the implication of these findings on educational, behavioral, and speech and language treatments will be discussed. Long term follow up studies describe patients who have optimal outcomes of ASD. The repetitive behavior domain in ASD, OCPD and OCD related disorders will be evaluated and implications for common underlying mechanisms discussed. New

targeted treatments for fragile-X syndrome and other genetically homogenous syndromal forms of ASD based on molecular mechanisms will be highlighted. Families often utilize complementary and integrative treatments for ASD and the evidence for such use, and risks and benefits of these treatments are discussed. Non-invasive brain stimulation techniques such as transcranial magnetic stimulation (TMS) have been studied for the treatment of core and associated symptom domains, and the promise and pitfalls of such treatment discussed.

Sunday, May 19, 2019

Assessing and Managing the Behavioral and Psychological Symptoms of Dementia

Chair: Art C. Walaszek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop a plan to assess the behavioral and psychological symptoms of dementia (BPSD), including medical and psychosocial contributions; 2) Describe the psychopharmacological options that may be useful for patients with BPSD; and 3) Develop an approach to the management of each of their patients with BPSD that includes behavioral and environmental interventions as primary and psychotropic medications as secondary

SUMMARY:

Alzheimer's disease and other causes of dementia are classified as neurocognitive disorders – but they are also very much disorders of emotion and behavior. Nearly 90% of people with dementia experience behavioral and psychological symptoms at some point during their illness. These symptoms profoundly affect quality of life, relationships with loved ones, personal safety, autonomy, dignity, and independence. The most common behavioral and psychological symptoms of dementia (BPSD) include agitation, depression, anxiety, apathy, and psychosis. The purpose of this session is to provide attendees with evidence-based, pragmatic, and clear recommendations regarding how to assess and manage their patients with BPSD. Prior to developing a plan to help a patient suffering from BPSD,

clinicians should identify the underlying cause of dementia, as this may influence both the understanding and treatment of BPSD. Next, a careful exploration of BPSD should be undertaken, characterizing each symptom, its frequency, and its intensity - in this session, will discuss approaches for doing so. Any medical problems, environmental factors, or medications that are determined to be contributing to the symptoms should be addressed. We will highlight the role of undetected pain in patients with BPSD, and discuss strategies for assessing and reducing pain. With respect to treatment of BPSD, we will emphasize the role of non-pharmacological interventions. Specifically, training of formal, paid caregivers seems to be the most effective intervention for BPSD. Other non-pharmacological interventions that may be of benefit include scheduling activities, music therapy, touch/massage, and other sensory interventions. Resources to support and educate patients, family members, and other caregivers should be provided. We will also discuss how to ensure that patients from underrepresented groups receive appropriate, culturally informed care. In general, pharmacological interventions should be prescribed only when BPSD are potentially dangerous to the person with dementia or to caregivers, or when BPSD cause significant distress to the person with dementia. We will discuss the evidence for and risks associated with the use of antidepressants, antipsychotics (including the FDA black box warning regarding mortality), anticonvulsants, benzodiazepines, anticonvulsants, and other agents. We will also discuss how treatment should be tailored based on the etiology of dementia. Finally, we will discuss specific threats to the safety of patients with BPSD and those caring for them, including aggression, wandering, suicidality, falls, driving, smoking (and fire safety), and financial exploitation.

Family Murder: Pathologies of Love and Hate

Chair: Susan Joy Hatters-Friedman, M.D.

Presenters: Jacqueline Landess, M.D., J.D., Alec W. Buchanan, M.D., Ph.D., Richard P. Martinez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe common themes in family murder; 2) List the motives for child murder

by parents; 3) Explain how understanding motives behind murders in the family helps aid in prevention; 4) Describe the common factors among children who kill their parents; and 5) List common factors among those who kill their partner

SUMMARY:

Cases of murder in the family often make for headline news. This presentation delves deeper into cases of family murder to examine the common factors, and to examine the motives for the various types of family homicide. From so doing, we can consider how to prevent murders in the family. First, the motives of parents who kill their children will be described. These cases range from the young woman with denial of pregnancy who commits neonaticide when the existence of the baby becomes a reality—to the loving mother of older children who kills altruistically in the throes of psychosis. Necessarily, different prevention strategies would be used. The panel will then discuss feticide: the unlawful murder of the unborn. Perpetrators range from male partners who do not wish to pay child support for an unwanted pregnancy, to women making suicide attempts which kill their fetus, to women stealing a baby by Caesarian. Next, turning to murder by the intimate partner, the various motivations will be described. Not all cases are intimate partner violence turned to murder, and not all perpetrators of intimate partner homicide are men. Following this, siblicide will be discussed. Siblicide can occur in youth, often due to poor parental monitoring when firearms or incendiary devices are in the home; and in adults, usually non-accidentally and after long-standing sibling rivalry. Finally, familicide cases involve the extermination of the entire family, and often the suicide of the perpetrator. These fulminant events are usually perpetrated by the father, whereas mothers may commonly commit filicide-suicide. Motives for familicide have much in common with individual murders in the family. After each of these subtypes of family murder is discussed, the audience will have a fuller understanding of the dynamics and risk factors for murder in the family. Various prevention strategies will also be discussed. This session will be highly interactive and encourage audience participation.

**Positive Psychiatry in Non-Clinical Settings:
Education and Coaching**

Chair: Richard Fredric Summers, M.D.

Presenters: Aviva Teitelbaum, M.D., Deanna

Constance Chaukos, M.D., Behdad Bozorgnia, M.D.

Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be aware of the principles of positive psychiatry as a framework for understanding and enhancing organizational functioning; 2) Apply positive psychiatry interventions in non-clinical settings such as medical education, legal education and executive coaching; and 3) Compare and contrast positive psychiatry interventions with traditional educational and coaching interventions

SUMMARY:

Positive psychiatry, while less familiar to clinicians than positive psychology, expands the perspective of traditional clinicians. Positive psychiatry may be defined as the science and practice of psychiatry that seeks to understand and promote well-being through assessments and interventions aimed at enhancing positive psychosocial factors among people who have or are at high risk for developing mental and physical illnesses (Jeste, et al., 2015; Summers & Jeste, 2018). Positive psychiatry is an approach to mental health that seeks to expand the scope of psychiatry to the promotion of well-being in the overall population. Positive psychosocial factors include resilience, optimism, social engagement, wisdom, post-traumatic growth, hope, compassion, self-efficacy, and personal mastery, among others. As a branch of medicine, positive psychiatry is also focused on discerning the biological substrates of these traits, including their neurocircuitry, neurochemistry, and genetic basis, as well as developing biomarkers of these positive factors (Jeste, et al., 2017). Importantly, positive psychiatry is not intended to replace traditional psychiatry but rather to complement it by shifting the focus from treating pathology to maintaining health and from treating symptoms to enhancing well-being. Previous panels have focused on the application of positive psychiatry to clinical settings. This panel will focus on their increasing application in non-clinical

settings, including medical education, executive coaching and legal education. The panel starts with an overview of the principles of positive psychiatry and then focuses on their application to non-clinical settings where there is increasingly robust evidence for their effectiveness. Panelists will discuss present and discuss medical education programs organized around positive psychiatry principles, positivity in executive coaching and positive legal education programs and how these programs optimize performance and satisfaction for their participants through their focus on positive emotions and strengths. Each panelist has extensive experience in positive psychiatry and will demonstrate their program with many specific examples. There will be ample time for discussion and audience participation.

Supervision in Psychiatric Practice: Practical Approaches Across Venues and Providers

Chair: Sallie G. DeGolia, M.D., M.P.H.

Presenter: Kathleen Corcoran, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the state of mental health supervision; 2) Describe the four phases of supervision; 3) Differentiate several key strategies used in supervision; 4) Identify potential unique issues associated with supervision; and 5) Outline faculty development for supervision

SUMMARY:

Despite supervision's central importance to psychiatry's professional training and work, most mental health supervisors receive little to no training on how to actually supervise. With the contributions of more than two dozen experts in their fields, we will review how Supervision in Psychiatric Practice establishes a practical framework for supervision grounded in real-world experience. This session will familiarize mental health providers with the four phases of supervision, the evidence base behind it, various techniques that can enhance the quality of supervision, and important issues relevant to supervision. The presentation will conclude with a review of the current state of supervision faculty development.

Monday, May 20, 2019

Meet the Author: *Clinical Handbook for the Evaluation and Treatment of Pediatric Mood Disorders*

Chair: Manpreet Singh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review content for an exciting new clinical handbook for the diagnosis and treatment of mood disorders in youth.; 2) Learn how to use the clinical handbook as a teaching tool for trainees and allied health professionals.; 3) Reference the clinical handbook to advance understanding of the diagnosis, neuroscience, and treatment of childhood onset mood disorders.; and 4) Apply the latest evidence based and FDA approved treatments for pediatric mood disorders into clinical practice.

SUMMARY:

A spectrum of mood disorders is increasingly being identified and treated in youth. We have learned much about mood disorders from the experience of adults, who often suffer a decade or more with symptoms before receiving an accurate diagnosis or adequate treatment. This lag in identification and treatment has resulted in progression of severity of mood disorders that are often challenging to treat. Contextualizing the early roots of mood disorders is imperative not just for clinicians working with children and adolescents, but also for psychiatric practice in adults. Emerging evidence also suggests that in youth offspring of parents with mood disorders, there is an increased risk compared to the general population for developing mood and other psychiatric conditions, and that there may be a differential response to psychotropic medications (toward increased side effects) based on this family risk. Clinicians and trainees frequently have questions about how to investigate common risk factors for developing lifelong mood problems. Inspired by these challenges, we assembled a team of experts in child psychiatry to write a handbook for a wide readership of trainees and professionals interested in understanding and treating pediatric onset mood disorders.

Physician Suicide: Cases and Commentaries

Chair: Peter M. Yellowlees, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of self-care for physicians, especially following a patient suicide; 2) Identify strategies required to engage and treat physician patients; 3) Be aware of curricula components to teach physicians about self-care; and 4) Be aware of individual and organizational change strategies designed to reduce the incidence of physician burnout

SUMMARY:

This session is designed to be a group discussion facilitated by Dr Yellowlees focused around a number of specific topics relevant to physician health and wellbeing. "Physician Suicide: Cases and Commentaries" is a textbook on physician health written in the style of Oliver Sacks. Each chapter comprises a long detailed realistic fictional case example followed by a commentary on the major issues uncovered by the case. For example chapter 1 is one of several cases in the book of a completed physician suicide, and is set during the funeral of a popular well loved physician who struggled with depression and alcohol abuse. The commentary in this chapter concentrates on the core professional beliefs that drive physicians practice and behavior, moving on to the epidemiology and clinical issues surrounding suicidality in physicians and the impact of a physician suicide on his psychiatrist. Dr Yellowlees will examine a number of the major issues and controversies in the area of physician health as they relate to psychiatrists, with continuous input and discussion from the attendees, and as illustrated within the book. These include: • How to treat physicians (as VIP's) with psychiatric disorders, and how to respond to physician suicides. • How to increase physician's personal resilience, and can this be taught. • How to manage physicians exhibiting disruptive behavior • Should physicians be routinely screened for alcohol and drugs, and how can they best be monitored • How to institute organizational change to reduce physician burnout Attendees are encouraged to bring questions and their own case examples from their practices. It is

envisaged that more than half the time will be spent in group discussion.

Practical Strategies in Geriatric Mental Health: Cases and Approaches

Chair: Laura B. Dunn, M.D.

Presenters: Marla Kokesh, M.D., Barbara R. Sommer, M.D., Erin Cassidy-Eagle, Ph.D., Alana Iglewicz, M.D., Daniel Kim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the assessment and management of older adults with anxiety symptoms.; 2) Identify key aspects of addressing insomnia and other sleep symptoms in older adults.; 3) Discuss the evaluation and management of bipolar disorder in older adults.; 4) Understand the primary do's and don't's of working with patients experiencing grief.; and 5) Describe the pharmacologic and non-pharmacologic management of behavioral symptoms in patients with dementia.

SUMMARY:

There is a large and growing need for mental health care for older adults suffering from a range of psychiatric and psychological symptoms and syndromes. The evaluation and treatment of older adults with affective, cognitive, and behavioral symptoms can seem intimidating to many providers. Moreover, clinical presentations are often “messy” among older patients—most patients have multiple medical problems. There may also be cognitive concerns on the part of the patient or their family. Thus, the so-called “chief complaint” frequently masks an underlying or latent problem or set of problems. Therefore, a great need exists for accessible, practical material to help psychiatrists and other providers meet the psychiatric needs of older adults, as well as work collaboratively and effectively with their families. To address this gap, this session will feature five presentations by geriatric psychiatrists and psychologists. Each presentation will center on a case that is typically seen by geriatric mental health providers. Each presentation will begin with a “chief complaint,” followed by a clinical vignette that fleshes out the chief complaint with relevant patient information. The audience will interact with the presenters

through the use of both open-ended questions (e.g., “What else do you want to know at this point?”) and multiple-choice questions integrated into the session. Each presenter will then provide a practically-oriented discussion of the differential diagnosis, evaluation, and pharmacologic and non-pharmacologic interventions for each of the scenarios. Each presentation will feature clear, take-home pearls for practitioners. Dr. Kokesh will address anxiety in older adults. Dr. Cassidy-Eagle will discuss the evaluation and management of insomnia in older adults. Dr. Sommer will describe the evaluation and management of bipolar disorder in older adults. Dr. Iglewicz will discuss grief in older adults, providing helpful do's and don'ts when working with grieving patients. Dr. Kim will describe the pharmacologic and non-pharmacologic management of behavioral and psychological symptoms in patients with dementia. This presentation features authors of chapters in the forthcoming book to be published by American Psychiatric Association Publishing, Inc., “Practical Strategies in Geriatric Mental Health: Cases and Approaches,” edited by Drs. Cassidy-Eagle and Dunn.

Tuesday, May 21, 2019

Culture, Diversity, and Older Adult Mental Health

Chair: Maria D. Llorente, M.D.

Presenters: Elspeth Cameron Ritchie, M.D., M.P.H., Rita R. Hargrave, M.D., Madeline Nykamp

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the changing demographics of the US population, towards living longer, and more diversity; 2) Understand that design of healthcare organizations with cultural sensitivity in mind improves access and overall medical and mental health care outcomes; and 3) List examples of unique aspects of healthcare, with samples provided by the panel, including Asian Americans, Veterans and centenarians

SUMMARY:

The Census Bureau is projecting that within 17 years, there will be more older adults than children in the US. These older adults are increasingly culturally and ethnically diverse. Racial and ethnic elderly have

unique needs, and particularly those who speak languages other than English, face large challenges and barriers to accessing medical care. Mental health is significantly impacted by a variety of factors, but importantly, heritage and culture are tremendous contributors, as well as unconscious biases. The major demographic transitions that this nation is facing will be summarized. Data will be provided to include centenarians, the fastest growing group of seniors, world wide. In many ways, this group offers a view of resiliency, and "lessons learned" in successful aging. Three sample groups of diverse seniors will be reviewed by the panel to illustrate key principles, including the unique aspects of that group, and followed by a description of the mental health care needs of the group. Finally, each panelist will summarize aspects of cultural sensitivity that will facilitate providing truly competent care when working with older adults from the particular group. The first group to be discussed will be African Americans. This group came to the US through the slave trade, and has had a complicated history. As a result, this heritage has had a significant impact on mental health needs and aspects of care and research. The second group discussed will be that of Asian American and Pacific Islanders. This is a highly varied group, with differing methods and motivations in migrating to the US. Concepts of acculturation and inherent bias will be reviewed. The third group to be discussed will include older Veterans. The current cohort of older Veterans are predominantly Vietnam Veterans, who were exposed to Agent Orange, and who are living with the sequelae of this exposure. In addition, this cohort of Veterans helped to define PTSD for all people. The panel will then open discussions to participants to share experiences with cultural competency in providing high quality mental health care and impact on healthcare outcomes.

Lifestyle Psychiatry

Chair: Douglas L. Noordsy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify the impact of physical exercise on neurotrophic factors and synaptic plasticity; 2) Participants will be able to identify the impact of

physical exercise on depression, cognitive function and negative symptoms; 3) Participants will be able to identify the impact of nutrition on risk for psychiatric disorders; and 4) Participants will be able to identify the impact of mind-body practices on anxiety and depression

SUMMARY:

With decades of biological psychiatry, neuroscience and advanced imaging techniques, the interface of mind and brain and their contributions to psychiatric disease remains an area of active discovery. This creates ongoing opportunities to optimize the balance between providing expert advice and empowerment of people in their own lifestyle choices as they assume responsibility for their mental health outcomes. The psychiatry of the future must balance advances in genetics, epigenetics, proteomics and brain biomarkers with strong grounding in lifestyle, health behaviors and wellness to meet the expectations of consumers and society. We have an opportunity to provide leadership on health behaviors that can transform public perceptions of mental health and disease. Being a student of lifestyle psychiatry and integrating it skillfully into your practice will prepare you to provide precise, effective and practical care that will serve you and your patients well, align psychiatry with general medicine, demonstrate integrity and engender trust. Psychiatry in the 21st century can leverage the intersection of neuroscience and behavioral science with technologic savvy to approach each individual holistically and engage the power of informed consumers taking ownership of their mental health and wellness. This presentation will summarize evidence on the impact of lifestyle interventions on prevention and treatment of psychiatric disorders, and leave you better prepared to implement them in your clinical practice.

Neuroscience-Informed Interventions for Youth With History of Traumatic Stress

Chair: Victor G. Carrion, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To review current state of the science on developmental traumatology; 2) To learn

new approach to treat youth with history of chronic traumatic stress; 3) To learn new preventive approach to improve coping skills in youth; and 4) To practice therapeutic techniques centered around cues of traumatic events

SUMMARY:

Thirty-five percent of youth living in communities of high violence will develop significant posttraumatic stress disorder symptoms. Current treatment modalities that anchor in cognitive behavioral therapy (CBT) may leave 20-50% of youth without adequate symptom relieve. New treatment modalities that address executive function, memory and emotion regulation are needed, and access and dissemination should be taken into consideration. This presentation will introduce Stanford's Cue-Centered Therapy (CCT) and a school-district wide prevention effort that involves yoga and mindfulness in students' curriculum. CCT integrates elements from CBT with other empirically validated interventions for traumatized youth (psychodynamic therapy, insight, self-efficacy, education). The prevention study focuses on health and wellness through meditation and exercise. Our research identifying key brain regions (e.g.; hippocampus, amygdala, prefrontal cortex) alterations in structure and function as related to traumatic stress informed the development of CCT. CCT demonstrated effectiveness in reducing anxiety, depression and posttraumatic stress symptoms in a randomized controlled trial. We are currently engaged in treatment outcome research to demonstrate CCT's efficacy in improving brain function and cognitive and emotional outcomes. This General Session will begin with a background on our imaging (sMRI and fMRI) and salivary cortisol studies that set the stage for the development of CCT. The session will focus on discussion and audience engagement on the therapeutic techniques highlighted by CCT. Lastly, prevention in the form of a structured yoga and mindfulness program (The Pure Power Curriculum) will be introduced along with preliminary findings from a multi-method (behavior, academics, cortisol, sleep imaging), longitudinal study on its effectiveness. New treatment modalities and dissemination plans need to be developed to address the highly heterogenous group of children that fall under the diagnostic umbrella of

posttraumatic stress disorder (PTSD). Approaching both prevention and treatment that are informed by neuroscience research promises to make our interventions more focused and targeted.

Wednesday, May 22, 2019

Evidence-Based Treatment Approaches for Suicidal Adolescents: Translating Science Into Practice

Chair: Michele Berk

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe evidence-based safety interventions for suicidal youth; 2) Describe the current evidence-based psychotherapy approaches for suicidal youth; and 3) Consider ways to incorporate elements of evidence-based treatment approaches for suicidal youth into his/her clinical practice

SUMMARY:

This will be a Meet the Author session for the book "Evidence-Based Treatment Approaches for Suicidal Adolescents: Translating Science into Practice," to be published by American Psychiatric Association Publishing. Suicide is currently the second leading cause of death among 10-24 year-olds in the United States (CDC, 2016). Hence, it is critical that mental health professionals who treat adolescents are familiar with evidence-based strategies for suicide prevention in this age group. The aim of this book is to provide clinicians with a review of existing evidence-based psychotherapy approaches for the treatment of suicidal adolescents, along with practical guidelines for how to implement these approaches into their existing practices. This book provides a practice-friendly review of six treatments that have been shown in randomized controlled trials to reduce suicidal and/or self-harm behavior in adolescents at high risk of suicide. The book also includes chapters on risk factors, evidence-based safety interventions and medication management with this population.

Courses

Saturday, May 18, 2019

Advanced Pharmacological Management for Depression: Applying the Latest Evidence-Based Treatment in Clinical Practice SOLD OUT

Directors: Roumen V. Milev, M.D., Ph.D., Raymond W. Lam, M.D.

Faculty: Sidney Kennedy, M.D., Daniel Mueller, M.D., Diane M. McIntosh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use clinical tools and algorithms to support measurement-based care for major depressive disorder; 2) Select an optimal antidepressant based on the latest clinical, biomarker, and pharmacogenetic guidelines; and 3) Use evidence-based strategies for the pharmacological management of treatment-resistant depression

SUMMARY:

This course is sold out.

Functional Neurological Disorder (Conversion Disorder): Update on Evaluation and Management

Directors: Gaston C. Baslet, M.D., W. Curt LaFrance, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Perform a comprehensive assessment in patients with functional neurological disorder (FND)/conversion disorder, incorporating input from test and exam results and other collaborating disciplines; 2) Communicate the diagnosis to the patient, his/her family, and collaborating clinicians in a way that reinforces engagement in treatment; 3) Recommend, seek advice, and/or execute the most appropriate treatment plan based on the current evidence from the medical literature; and 4) Understand the complexity and heterogeneity of this patient population and recognize various modifiable risk factors that should be considered targets for treatment

SUMMARY:

Functional neurological disorder (FND, also named conversion disorder [CD]) is encountered in a sizable proportion of patients seen in neurological,

emergency medicine, and primary care practices. Treatment usually requires the expertise of mental health professionals, including psychiatrists. Despite improved understanding and growing interest in the development of treatment options in FND/CD, clear guidelines for the management of this complex population are still lacking. This course will review the role of the neurologist and the psychiatrist during the diagnosis and management of patients with FND/CD. We will provide an overview of our current understanding of the risk factors and a biopsychosocial model of this disorder. The course will focus on practical interventions, including guidelines for a comprehensive initial neuropsychiatric evaluation. Effectively communicating the diagnosis to patients, families, and collaborating clinicians is crucial. We will discuss the different stages of treatment, including engagement, evidence-based short-term interventions, and strategies for the long-term treatment of patients with FND/CD. The course faculty will emphasize and illustrate how to collaborate with the multitude of disciplines involved in the care of these patients. Faculty who possess a wealth of clinical experience in the evaluation and treatment of this population will present illustrative cases showcasing the complexity and heterogeneity of patients with FND/CD. Participation from the audience will be encouraged, including discussion of their cases.

Good Psychiatric Management for Borderline Personality Disorder

Director: Brian A. Palmer, M.D., M.P.H.

Faculty: Lois W. Choi-Kain, M.D., John Gunder Gunderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Diagnose borderline personality disorder correctly, including differentiating from mood disorders and explaining the diagnosis to a patient; 2) Articulate principles for management of safety issues in patients with borderline personality disorder; 3) Describe the course and outcome of BPD and the impact of BPD on mood disorders and vice versa; 4) Explain key principles and evidence in the pharmacological treatment of BPD; and 5)

Understand the role of split treatments and family involvement in the treatment of BPD

SUMMARY:

This course will teach psychiatrists the basics of what they need to know to become capable, and comfortable, in treating patients with borderline personality disorder. The good psychiatric management taught in the course has been compared in a randomized study with dialectical behavioral therapy and performed equally well. Its contents have been developed as a handbook. The course begins with a focus on interpersonal hypersensitivity as a unifying feature of the disorder. Through interactive cases, video illustrations of principles, and ample time for questions and answers, participants will develop skills in diagnosing BPD, understanding its course and outcome, starting treatment, applying principles of psychopharmacology, and effectively collaborating in multi-provider treatments. Basic information about the impact of BPD on other psychiatric and medical disorders (and vice versa) will help participants more effectively formulate care and treatment of patients with BPD and other disorders. Appropriate family involvement and key psychoeducational principles for families are included. Previous course participants have noted improvement in self-perceived skills in the treatment of BPD as they grow more confident in applying key principles in treatment.

Talking With and Listening to Your Patients About Marijuana: What Psychiatrists Should Know

Director: Henry Samuel Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review limitations on current scientific knowledge of marijuana; 2) Review history of marijuana use in medicine; 3) Review biochemistry of exogenous and endogenous cannabinoids and their unique biological actions, receptors, approved cannabinoid preparations, metabolism, and routes of administration; 4) Review clinical research data on the effects of marijuana upon psychiatric and nonpsychiatric conditions and upon behaviors such as violence, as well as its potential hazards; and 5) Discuss how to address

providers' legal/ethical/documentation and history-taking issues and patients' questions, concerns, and educational needs regarding marijuana use

SUMMARY:

Marijuana, according to NIDA, is “the most commonly used illicit substance.” However, according to state but not federal laws, medical marijuana is legal in 33 states and DC. Ten states have also legalized recreational marijuana. As legalization of marijuana grows, more patients are turning to us, their doctors, for advice and information about marijuana’s risks and benefits. Many patients with medical/psychiatric illness use marijuana recreationally as well, with little knowledge of its effects. Both groups deserve education from us based on scientifically derived data. However, despite research to the contrary, the U.S. government still considers marijuana a Schedule I substance “with no currently accepted medical use and a high potential for abuse.” The federal stance inhibits research on the science of marijuana and has promoted attitudes toward marijuana’s risks and benefits that are not objective or scientifically based. We need to be able to counsel and educate our patients based on objective, scientific data. Too much is said with authority about medical aspects of marijuana—pro and con—that is misleading and deceptive. This course will teach the practitioner to understand the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. The faculty will review the 4,750-year-long history of cannabis use in medicine and the recent history of restrictions on research and use of cannabis in the U.S. We will discuss the cannabinoid system, CB1 and CB2 receptors, and their distribution and function, as well as the endogenous cannabinoids. We will cover cannabis’ routes of administration, bioavailability, distribution and elimination, and the unique actions of various cannabinoids. We will then present clinical research and its limitations on the effects of cannabis in psychiatric conditions, including anxiety, depression, psychosis, PTSD, and sleep, and its role in violence. We will also review clinical research on its effects in nonpsychiatric medicine, including its actions in inflammation, pain, spastic diseases, appetite loss, nausea, epilepsy, and HIV. We will present data on FDA-approved cannabinoids. The faculty will detail

hazards of cannabis use, including use in pregnancy, addiction, accidents, psychosis, cognitive deficits, withdrawal, heart and lung illnesses, reproductive effects, and other symptoms. We will discuss synthetic cannabinoids. We will describe the malpractice risks, legal restrictions, and limitations on medical practitioners who may be asked by their patients to issue a “cannabis card.” We will teach the practitioner to take a history relevant to the use of medical cannabis. We will discuss ways to listen to and talk with patients who consider using or are actively using cannabis for medical reasons, or who are using cannabis recreationally while in treatment for a psychiatric or other medical disorder. We will not address screening for or treatment of addiction.

Updates in Geriatric Psychiatry

Director: Rajesh R. Tampi, M.D., M.S.

Faculty: Meera Balasubramaniam, M.B.B.S., M.P.H., Aarti Gupta, M.D., Brandon C. Yarns, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the epidemiology, neurobiology, assessment, and management of neurocognitive disorders; 2) Describe the epidemiology, and management of behavioral and psychological symptoms of neurocognitive disorders; 3) Elaborate on the epidemiology, and management of substance use disorders in late life; 4) Enumerate on epidemiology, and management of anxiety and mood disorders in late life; and 5) Define the epidemiology, and management of psychotic disorders in late life

SUMMARY:

Psychiatric disorders are not uncommon in late life. Illnesses like neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders are frequently encountered among the older adults. As the population of older adults in the United States is growing rapidly, the number of older adults with psychiatric disorders seeking care in the health care system has increased. In this course, we will review the common psychiatric disorders seen in late life, including neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders,

mood disorders, anxiety disorders, psychotic disorders, and substance use disorders. This course is intended for practitioners who want to gain expertise and be engaged in the care of older adults with these psychiatric disorders using the most evidence-based and innovative treatments currently available. This course provides the most up-to-date information on the assessment and treatment of neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life. This course will be taught by award-winning geriatric psychiatrists who have expertise in teaching courses in geriatric psychiatry.

Sunday, May 19, 2019

Eating Disorders for the General Psychiatrist

Directors: Evelyn Attia, M.D., B. Timothy Walsh, M.D.

Faculty: Michael James Devlin, M.D., Deborah Glasofer, Ph.D., Neville Golden, Daniel Le Grange

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize and begin to utilize evidence-based medication treatments for eating disorders; 2) Recognize and begin to utilize medical management for adolescents and adults with eating disorders; 3) Recognize and begin to utilize family-based treatment (FBT) for adolescents with eating disorders; 4) Recognize and begin to utilize psychological and psychiatric issues associated with obesity; and 5) Recognize and begin to utilize case management for complexing patients with eating disorders, including those with co-occurring psychiatric conditions

SUMMARY:

Eating disorders are serious psychiatric illnesses associated with high rates of morbidity and mortality. They affect more than 10 million individuals in the U.S. and account for increasing rates of disability among adolescents and young adults worldwide, according to studies of the global burden of disease. Eating disorders are frequently associated with other psychiatric symptoms and syndromes, including mood, anxiety, and substance use disorders. Psychiatrists and other mental health

clinicians who may not specialize in eating disorder treatments will commonly identify eating and weight problems among their patients and may not know how best to manage these features. Even among providers who more regularly see patients with eating disorders, treatment may be challenging, especially in cases of severely affected patients who resist treatment interventions or present with co-occurring conditions. This course serves as a clinical update on eating disorders for the general psychiatrist. The lectures will include an overview by Dr. B. Timothy Walsh of effective medication treatments eating disorders, including anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). Dr. Neville Golden will review medical complications of eating disorders and discuss the management of the medical features that may present in adolescent and adult patients. Dr. Daniel Le Grange will present a clinical and research update about treatments for children and adolescents with eating disorders, including family-based treatments (FBT). Dr. Michael Devlin will discuss psychological features associated with obesity, emphasizing what a psychiatrist needs to know when caring for an obese patient. Drs. Evelyn Attia and Deborah Glasofer will lead a case-based discussion about management of complex patients with eating disorders, including those with severe and enduring illness and those with co-occurring psychiatric conditions. Drs. Attia and Glasofer will use case material and will offer interactive opportunities for audience members.

**First-Episode Psychosis for the General Clinician:
From Assessment to Treatment**

Director: Steven N. Adelsheim, M.D.

Faculty: Jacob S. Ballon, M.D., Douglas L. Noordsy, M.D., Kate Hardy, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Document the key components of appropriate assessment for early psychosis; 2) List the components of the Coordinated Specialty Care model; 3) Have a strong understanding of the core workup and treatment components for a person with early psychosis; and 4) Explain the different approach to assessment and treatment for the adolescent with early psychosis symptoms

SUMMARY:

Early recognition and intervention for young people with early psychosis has become a national priority. With the results of the NIMH-supported RA1SE studies and the ongoing NAPLS study for those with clinical high risk (CHR) for psychosis, the research base supporting early intervention for psychosis has continued to grow. As a result of these federal research commitments and the recognized importance of shortened duration of untreated psychosis (DUP) in improving long-term outcomes for those with psychotic illness, the U.S. government has made the financial commitment to support expanded funding for early psychosis programs in each state. As a result, the number of U.S. early psychosis clinical programs has grown to almost 300 over the past several years. Psychiatrists are instrumental team members as part of the coordinated specialty care team supporting those with CRH and early psychosis. Unfortunately, many psychiatrists have not been trained in the current models of assessment and treatment that have been found to be most effective in supporting young people at risk for or with early psychosis. This course will provide training for the general psychiatrist in the key aspects of assessment, workup, and intervention for the young person at risk for or facing a first episode of psychosis. The course components include an initial focus on diagnostic and assessment issues in the approach to CHR intervention and early psychosis. This training will include clarifying differential diagnosis issues, the use of the SIPS in diagnostic assessment, and information about the staging model for early psychosis. Key components of an appropriate workup for early psychosis, including interview focus, screens, bloodwork, and consideration of neurological assessment will also be discussed. Intervention components will focus on the continuum of care, including CBT for psychosis, family intervention, medication support, supported education, and peer support. This focus area will also include information on the shared decision-making model for collaboration with the identified patient and family. Furthermore, an additional focus will include special considerations in working with the adolescent with early psychosis and their family, school, and community environment.

Imminent Suicide Risk Assessment in High-Risk Individuals Denying Suicidal Ideation or Intent

Director: Igor I. Galynker, M.D., Ph.D.

Faculty: Paul J. Rosenfield, M.D., Sarah Bloch-Elkouby, Ph.D., Shira Barzilay, Ph.D., Raffaella Calati, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the difference between long-term and imminent suicide risk; 2) Learn the nuts and bolts of MARIS- and NCM-based approaches to the assessment of imminent risk; and 3) Apply the MARIS- and NCM-based approaches to assess imminent suicide risk in test cases

SUMMARY:

According to the recent Centers for Disease Control (CDC) report, more than half of suicide decedents between 2000 and 2016 were never diagnosed with a mental health condition, and only a quarter disclosed suicide intent prior to ending their lives. These striking findings challenge the practice of using suicidal ideation as a cornerstone of suicide risk assessment and may partially account for our failure to contain the increase in U.S. suicide deaths. The CDC report also underscores the urgent need for innovative suicide risk assessment methods that do not rely on a history of mental illness or self-reported suicidal ideation/intent. This course trains clinicians in a novel framework for the assessment of short-term suicide risk: the Modular Assessment of Risk for Imminent Suicide (MARIS) and the Narrative-Crisis Model of Suicidal Behavior (NCM). The effectiveness of the MARIS-NCM approach is described in multiple peer-reviewed publications and in the book *The Suicidal Crisis* by Igor Galynker (2017; Oxford University Press), now a recommended resource by the American Foundation for Suicide Prevention. In the course, our team will train clinicians in the use of the two-part MARIS-NCM suicide risk assessment. The patient-focused part A evaluates the severity of the suicide crisis syndrome and the intensity of the suicidal narrative. The clinician-focused part B identifies clinicians' emotional responses to suicidal patients, which are predictive of imminent suicidal behavior. Igor Galynker, M.D., Ph.D., and Paul Rosenfield, M.D., will

present an overview of the research findings supporting the use of MARIS and NCM for the assessment of imminent suicidal risk. Subsequently, Sarah Bloch-Elkouby, Ph.D., will present a videotaped interview with a simulated patient, which will illustrate the clinical value of the MARIS-NCM framework. Next, Drs. Galynker, Rosenfield, Bloch-Elkouby, Barzilay, and Calati will train the course participants in the MARIS-NCM method. In the last didactic section, Shira Barzilay, Ph.D., will describe the use of clinicians' emotional responses as tools for assessment and management of imminent suicidal behavior, and Raffaella Calati, Ph.D., will discuss clinicians' psychological defense mechanisms elicited by suicidal patients. The course will conclude with participants evaluating their acquired skills through risk assessment evaluation of provided test cases.

Mean Girls (and Boys): A Clinician's Guide for Addressing School Violence

Directors: Anne Baden McBride, M.D., Michael Brian Kelly, M.D.

Faculty: Amy Barnhorst, M.D., Kelli Smith, M.D., Marcia Unger, M.D., M.P.H., Sophie Rosseel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the hallmark features of hot and cold aggression; 2) Summarize static and dynamic risk factors pertaining to school violence; 3) Distinguish the salient features of structured professional judgment and actuarial violence risk assessment measures; and 4) Characterize approaches to addressing school violence at the individual, school, and community levels

SUMMARY:

The topic of school violence garners a lot of attention in the media despite its overall decline in recent decades. High profile incidents of school violence, television shows, and movies have contributed to a typecasting of youth who commit violent acts at school. However, the general public's perception of how school violence occurs often does not reflect reality. In general, predicting violence is a difficult task for mental health clinicians. Furthermore, the fact that many youth who

perpetrate violence at school lack extensive histories of violent behavior makes attempts at predicting the likelihood of school violence particularly difficult. This course is designed to familiarize mental health clinicians with current methods of identifying risk factors for school violence, assess its likelihood, intervene, and respond to school violence. We will begin with a review of adaptive and maladaptive forms of aggression followed by a discussion of risk factors for school violence. Mass school shooters and the association with mental health will be discussed as well as an overview on threat assessment. Other specific types of school violence, including physical violence, bullying, sexual violence, and violence at home, will be reviewed. Next, participants will learn principles involved in the assessment of students' risk of violence and the utility of incorporating formal risk assessment tools when appropriate. Our discussion will incorporate a review of what schools can do to intervene and respond to school violence, including some case examples.

Neuromodulation Essentials: ECT, TMS, DBS, VNS, and Other Innovative Techniques

Director: Richard Calvin Holbert, M.D.

Faculty: Khurshid A. Khurshid, M.D., Uma

Suryadevara, M.D., Dawn-Christi M. Bruijnzeel, M.D.,

Robert N. Averbuch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the indications, techniques, neurobiology, adverse effects (including cognitive side effects), and neurobiological changes associated with electroconvulsive therapy; 2) Explain the indications, techniques (including motor threshold determination), adverse effects, contraindications, and efficacy of transcranial magnetic stimulation; 3) Explain the role of vagus nerve stimulation in treatment-resistant major depressive disorder; 4) Summarize the current use of deep brain stimulation in psychiatry; and 5) Recognize innovative neuromodulation techniques such as FEAST, tDCS, tACS, MST, CES, and micromagnetic stimulation

SUMMARY:

Neuromodulation techniques are playing an increasingly important role in the treatment of psychiatric disorders. While the Food and Drug Administration (FDA) has approved electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and vagal nerve stimulation (VNS) for treating episodes of major depressive disorder (MDD), research utilizing neuromodulation for treatment of other psychiatric disorders continues to expand. Hence, there is a real need for psychiatrists to improve their understanding of current neuromodulatory options for the treatment of their patients. With continuing innovation, we anticipate these biological therapies will become mainstays of treatment in the future. ECT remains the most effective treatment for severe MDD but can cause significant cognitive side effects. We will review the subtypes of ECT, indications, risks (including cognitive side effects), efficacy, and management afterward. Videos demonstrating the techniques will be shown. TMS is FDA approved for treatment-resistant depression and obsessive-compulsive disorder (OCD). A number of clinical trials are currently underway to obtain FDA clearance for other disorders. TMS induces an electrical stimulation through an electromagnetic coil producing small alternating currents in the brain. We will discuss indications, contraindications, side effects, and neurobiological effects produced by TMS. The determination of motor threshold, a necessary step in determining location and intensity of treatment, will be demonstrated through video. Innovative techniques such as deep brain stimulation (DBS), transcranial direct current (tDCS) and alternating current stimulation (tACS), focal electrically administered seizure therapy (FEAST), magnetic seizure therapy (MST), cranial electrotherapy stimulation (CES), and micromagnetic stimulation will also be reviewed. In exploring the role of DBS in OCD, we will cover the selection of patients, risks, components, implant locations, programming, and treatment course. The use of neuromodulation in children and adolescents is increasing. We will focus here on the use of ECT and TMS in patients with autism spectrum disorder and major depressive disorder, reviewing the literature and discussing case examples. The faculty have significant experience in using neuromodulation techniques clinically and in research protocols, as

well as giving lectures, seminars, and workshops at local and national meetings. Ample time to answer questions will be provided.

Neuropsychiatric Masquerades: Medical and Neurological Disorders That Present With Psychiatric Symptoms

Director: Jose R. Maldonado, M.D.

Faculty: Yelizaveta Sher, M.D., Sheila Lahijani, M.D., Filza Hussain, M.D., Andrea Ament, M.D., Mira Zein, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the incidence, epidemiology, and clinical features of the most common CNS disorders masquerading as psychiatric illness; 2) Integrate knowledge of current psychiatry into discussions with patients; and 3) Apply quality improvement strategies to improve clinical care

SUMMARY:

Psychiatric masquerades are medical and/or neurological conditions, which present primarily with psychiatric or behavioral symptoms. It is important for psychiatrists to recognize the variety of medical conditions that present with neurobehavioral symptoms, thus masquerading as a mental disorder. A high level of suspicion and the correct identification of the underlying process are paramount to initiate adequate treatment. This course will focus on the important differential of such disorders, common presentations, and guidelines for treatment. This course will provide participants with the necessary background to help practitioners identify the medical conditions presenting with behavioral abnormalities and associated conditions included in their differential diagnosis. The course will be divided into six groups: an introduction to neuropsychiatric masquerades and discussion of six representative clinical cases as introduction to the topics to be covered. For this purpose, we will use an electronic polling system for the audience to participate in the discussion of the differential diagnosis and tests that would be required arriving at the correct diagnosis. Then, we will discuss the neurobehavioral disorders included in each of the diagnostic classes: endocrine disorders (e.g., thyroid, adrenal, parathyroid, pancreatic and

gonads related disorders), metabolic disorders (e.g., Wilson's disease, hepatic encephalopathy, uremic encephalopathy, porphyria, and nutritional deficiencies), infectious diseases (e.g., neurocysticercosis, CNS tuberculosis, neurosyphilis, neuroborreliosis, herpes encephalitis, PANDAS, HIV, and antimicrobial-induced neurobehavioral effects), autoimmune disorders (e.g., SLE, MS, the brain-gut axis, and paraneoplastic syndromes), neurological disorders (e.g., epilepsy, behavioral and psychiatric symptoms of dementia, catatonia, posterior reversible encephalopathy syndrome (PRES), and delirium and delirium tremens). Presenters will focus on pearls for timely diagnosis and discuss potential management and treatment strategies. The proper workup and correct identification of the underlying process relies on accurate history taking, careful mental status examination, neurological exam, obtaining collateral information, and supporting laboratory and imaging data.

Risk Assessment for Violence

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Specify four types of paranoid delusions that can lead to homicide; 2) Identify the relative risk of violence in schizophrenia, bipolar disorder, and substance abuse; and 3) Indicate three factors that increase the likelihood that violent command hallucinations will be obeyed

SUMMARY:

This course is designed to provide a practical map through the marshy minefield of uncertainty in risk assessment for violence. Recent research on the validity of psychiatric predictions of violence will be presented. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be reviewed. Dangerousness will be discussed in persons with psychosis, mania, depression, and substance abuse. Special attention will be given to persons with specific delusions, command hallucinations, premenstrual tension, and homosexual panic. Personality traits associated with violence will be discussed. Childhood antecedents of adult violence will be covered. Advice will be given on taking a history from potentially dangerous

patients and countertransference feelings. Instruction will be given in the elucidation of violent threats, sexual assaults, and “perceived intentionality.”

Street Drugs and Disorders: Overview and Treatment of Dual Diagnosis Patients

Director: John W. Tsuang, M.D.

Faculty: Timothy W. Fong, M.D., Larissa J. Mooney, M.D., Reef Karim, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Know the emerging data for prevalence of opiate abuse and other drugs of abuse; 2) Know the new street drugs and club drugs; 3) Know the available pharmacological agents for treatment of co-occurring disorder patients; and 4) Learn the psychosocial treatment for co-occurring disorder patients

SUMMARY:

Rates of addiction to prescription painkillers and heroin use have skyrocketed in the last few years, and deaths from overdose have simultaneously increased significantly. According to the NSDUH survey of 2015, there are significant numbers of people who are using other drugs as well. The NESARC study of 2001 showed that individuals with lifetime substance use disorder have much higher rates of mood and anxiety disorders. These so-called co-occurring disorder patients are extremely difficult to treat and are big utilizers of public health services. This course is designed to familiarize participants with diagnosis and state-of-the-art treatment for these patients. We will first review the different substances of abuse, with a focus on opiate addiction and other emerging drugs, and their psychiatric manifestations. Issues and difficulties relating to the treatment of this population will be stressed. The available pharmacological agents for treatment and medication management strategy will be covered. Additionally, participants will learn about additional psychosocial interventions available for treatment.

The Psychiatrist as Expert Witness: The Ins and Outs of Being a Forensic Consultant

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Give more effective expert witness testimony; 2) Understand rules of evidence and courtroom privilege; and 3) Understand issues of power and control in the witness/cross-examiner relationship

SUMMARY:

Trial procedure and rules of evidence governing fact and expert witnesses will be reviewed briefly. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre-trial conferences and depositions. Participants will learn to cope with cross-examiners who attack credentials, witness bias, adequacy of examination, and the validity of the expert’s reasoning. Issues of power and control in the witness/cross-examiner relationship will be explored. Participants will learn how to answer questions about fees, pre-trial conferences, and questions from textbooks. The use of jargon, humor, and sarcasm will be covered. Different styles of testimony and cross-examination techniques will be illustrated by eight videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of suggestions for witnesses in depositions, 15 trick questions by attorneys, and over 50 suggestions for attorneys cross-examining psychiatrists.

Monday, May 20, 2019

Become a CPT Coding Master: Avoiding Hazards, Maximizing Opportunities, and Anticipating Changes

Director: Gregory G. Harris, M.D., M.P.H.

Faculty: Patrick Ying, M.D., Ronald M. Burd, M.D., Jeremy Seth Musher, M.D., Junji Takeshita, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine the correct CPT code

to use in a variety of practice settings; 2) Understand the necessary documentation required for these CPT codes; 3) Identify areas that are scrutinized closely by third-party payors; and 4) Understand the use of CPT codes in special circumstances such as prolonged care, telemedicine, collaborative care, and the use of screening tools

SUMMARY:

In this course, experts from the Committee on RBRVS, Codes, and Reimbursements will review proper CPT coding and documentation in order to help participants avoid costly audits while ensuring appropriate reimbursement for services rendered. Drawn from actual inquiries from the APA Practice Management Helpline, interactions with CMS and other regulatory bodies, and experiences with third-party audits, case scenarios will be presented that will highlight the most common pitfall situations, areas of particular scrutiny with third-party payors, and the most frequently misunderstood coding concepts. In addition, cases will highlight rule changes that allow for new opportunities such as collaborative care codes, prolonged services codes, integrating screening tools, telemedicine, and transitional care codes. Cases will represent the breadth of practice locations: outpatient, inpatient, emergency room, consultation, and nursing homes, as well as telephone and telepsychiatry visits. In addition, the potential impact of significant proposed changes to E/M documentation by CMS will be discussed. Following each case, questions will be posed to participants and, using audience-response technology, attendees will be able to assess their own knowledge of CPT coding and guide the level of discussion of the cases. Based on audience responses, the panel moderator has the ability to select from a large bank of cases in order to reflect the audience's interests and level of expertise. An hour of the course will be dedicated to participants presenting their own cases and questions to the panel of coding experts. The course faculty are national experts in the area of CPT coding and documentation for psychiatric services. Several hold appointed positions on the AMA CPT Advisory Committee and AMA/Specialty Society RVS Update Committee (RUC). All are experienced billing/coding and documentation educators and members of the

APA Committee on RBRVS, Codes, and Reimbursements.

Clinically Relevant Forensic Psychiatry: A Practical Review

Director: Tobias Diamond Wasser, M.D.

Faculty: Reena Kapoor, M.D., Charles Dike, MB.Ch.B., M.P.H., Alexander Westphal, M.D., Ph.D., Maya Prabhu, M.D., LL.B., Katherine Michaelsen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the significance of forensic issues in the everyday practice of clinical psychiatry; 2) Demonstrate knowledge of clinically relevant topics and principles in forensic psychiatry; and 3) Apply forensic knowledge to clinical encounters with patients

SUMMARY:

Many psychiatrists feel uncomfortable when "forensic issues" arise in clinical practice. Although the Accreditation Council for Graduate Medical Education (ACGME) has long required education in forensic psychiatry as a component of general psychiatry training, the quality of this educational experience varies widely. Some institutions lack access to forensic psychiatrists and, despite the ACGME requirements, some psychiatrists leave residency without a thorough understanding of forensic psychiatry or its application to clinical practice. Furthermore, although an understanding of the legal regulation of psychiatric practice is relevant to all psychiatrists, many are intimidated or overwhelmed by this aspect of their work due to a fear of the legal system or its potential consequences (e.g., litigation). In this course, faculty will address this knowledge gap by presenting a number of brief, interactive, and case-based didactic sessions on clinically relevant concepts within forensic psychiatry. The faculty, who are all experts in the field of forensic psychiatry, will cover clinically relevant topics (e.g., violence risk assessment, Tarasoff warnings, decision-making capacity, involuntary treatment, malpractice). Each presentation will begin with an overview of the subject area, followed by a brief review of the most up-to-date literature on the topic. During the course, participants will break into small groups to consider

challenging clinical case vignettes synthesized from historical legal or clinical cases relevant to each subject area. These cases will place participants in the role of the treater and ask them to consider how they would approach the clinical dilemmas. The larger group will then review strategies for approaching the cases. Finally, time will be devoted at the end of the session for participants to ask their own clinical questions of the faculty and other course participants. Utilizing this format, participants will improve their understanding not only of important forensic principles, but also their application in everyday clinical practice.

Emergency Psychiatry: The Basics and Beyond

Director: Kimberly D. Nordstrom, M.D., J.D.

Faculty: Leslie Zun, M.D., Jon Scott Berlin, M.D., Seth M. Powsner, M.D., Scott L. Zeller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand “medical clearance” and why universal labs are not helpful; 2) Have tools to engage agitated patients; 3) Have a better understanding of when to (or not to) start medications on someone in an emergency or crisis setting; and 4) Have good working knowledge on nonpharmacological and pharmacological treatments for agitation

SUMMARY:

No matter in what type of environment you practice psychiatry, you will experience patients who are in crisis. Behavioral emergencies may occur in any setting—outpatient, inpatient, emergency departments, and in the community. When psychiatric emergencies occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes differentiating a clinical emergency from a social emergency. This course can serve as a primer or as an update for psychiatrists in the evaluation and management of psychiatric emergencies. The course faculty offer decades of experience in emergency psychiatry. Participants will learn about the role of medical and psychiatric evaluations and the use of risk assessment of patients in crisis. The course

faculty will delve into when laboratory or other studies may be necessary and note instances when this information does not change treatment course. Tools, such as protocols, to aid in collaboration with the emergency physician will be examined. The art of creating alliances and tools for engaging the crisis patient will be discussed. Participants will also learn about the management of agitation (de-escalation and medication use), and special emphasis will be given to psychopharmacological treatments in the emergency setting. The course is divided into two parts; the first focuses on evaluation and the second on treatment. To round out the lectures on treatment, the director will ask questions of the presenters to highlight practice differences. A combination of lectures and case discussion cover fundamental and pragmatic skills to identify, assess, triage, and manage a range of clinical crises. Course faculty include emergency psychiatrists and an emergency medicine physician to help provide various viewpoints and allow for rich discussion. The course will close with the course director leading a debate with faculty over best treatments for specific case scenarios. The points of this exercise are to demonstrate that there is not one “right” answer and to exhibit the thought process behind treatment decisions.

Mind-Body Treatments for Global Mental Health Issues, Mass Disasters, Refugees, and PTSD: Lecture and Experiential

Director: Patricia Lynn Gerberg, M.D.

Faculty: Richard Paul Brown, M.D., Chris Conway Streeter, M.D., Gretchen Steidle, Somiari Demm, M.A., Samier Mansur

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List four advantages for using simple, effective, evidence-based mind-body programs to support the emotional recovery of populations affected by mass disasters; 2) Apply polyvagal theory to understanding how voluntarily regulated breathing practices (VRBPs) help shift the organism from states of defensive disconnection toward a state of safety and connectedness; 3) Describe initiatives using mind-body techniques to relieve stress and trauma among survivors of war and terrorism in Africa, Asia, and the United States;

4) Experience coherent breathing for stress reduction and learn how VRBPs can be used to reduce anxiety, insomnia, depression, and symptoms of PTSD; and 5) Acquire tools and resources to integrate breath and movement techniques experienced in this course into clinical practice

SUMMARY:

This update of Mind-Body and Breath Techniques for Stress, Anxiety, Depression, and PTSD focuses on international, cross-cultural trauma recovery for adult and child survivors of mass disasters. Breath-Body-Mind (BBM) uses simple practices, mainly voluntarily regulated breathing practices (VRBPs) with movement, mindfulness, and attention focus derived from yoga, qigong, martial arts, and neuropsychiatry. Easily learned, evidence-based techniques help relieve stress, anxiety, depression, and PTSD; are accepted across cultures; and can be modified for office, hospital, family and group therapy, schools, military bases, or disaster settings. Evolving neurophysiological theory shows how VRBPs may improve sympathovagal balance and emotion regulation, incorporates polyvagal theory (Stephen Porges), GABA pathways, neuroendocrine response, and social engagement networks. Specific mind-body practices reduce defensive reactions while restoring capacities for meaningful connectedness with self and others. Dr. Patricia Gerbarg updates evidence that VRBPs and related practices improve symptoms in GAD and PTSD patients, caregiver stress, and disaster survivors (2004 Southeast Asian tsunami; 9/11 World Trade Center; Middle East refugees; war, genocide, and trafficking in Africa). Dr. Chris Streeter presents an RCT showing effects of yoga plus coherent breathing on depression, heart rate variability, and brain GABA levels (MRS). Gretchen Steidle, founder/president of Global Grassroots, an international organization that leads a social venture incubator, mindful leadership program for women and girls in East Africa, describes how Global Grassroots brings BBM to disaster survivors in Haiti, Rwanda, and Northern Uganda and African refugees across cultures, religions, and languages. Somiari Demm created a yoga/spiritual wellness program for escaped and released Chibok students and is trauma specialist for the David Oyelowo Leadership Scholarship Program for Boko Haram survivors. She shares insights from

her experience as psychologist/advocate for the Nigerian Chibok girls since their return from captivity. Samier Mansur is cofounder of LiveSafe and founder of Safe Haven School for Rohingya refugee children in Bangladesh and No Limit Generation, a global platform to support NGOs, aid workers, and caregivers to create safe, nurturing environments that foster healing for refugee and at-risk children. Most relief workers provide food, shelter, and medical care, but training to address emotional needs of traumatized refugees is lacking. He discusses the role of BBM for Safe Haven School and educational initiatives. Dr. Richard Brown leads rounds of gentle movement (standing or sitting), VRBPs, and open focus. Awareness/mindfulness of breath and mental/physical state are cultivated. Group processes enhance learning. Attendees practice teaching coherent breathing under faculty supervision.

Positive Psychiatry Across the Lifespan

Directors: R. Rao Gogineni, M.D., Dilip V. Jeste, M.D.

Faculty: Samantha V. Boardman, M.D., Helen Lavretsky, M.D., David C. Rettew, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop a working knowledge of the principles underlying positive psychiatry and its relevance across the lifespan; 2) Gain an understanding of the application of positive psychiatry interventions in the treatment and prevention of mental illness in adults; 3) Learn about resilience-building mind-body interventions in older adults; 4) Learn positive psychiatry approaches to children and adolescents; and 5) Discuss and practice their new skills using clinical examples and case studies

SUMMARY:

This course will provide a deep exploration of positive psychiatry and will focus on the development of real-world skills in positive psychiatry that attendees can put into practice upon completing the course. Handouts and other tools attendees can use in their practice will be provided, and real-world interactive cases will be discussed. Well-being and positive functioning are core elements of mental health, not just the absence of

illness. Positive psychiatry is a new branch of psychiatry that aims to broaden the focus of psychiatry beyond suffering and alleviation of symptoms. It is the scientific study of optimal functioning, well-being, resilience, and mental health. Through assessments and interventions aimed at enhancing positive psychosocial factors among people who have or are at risk for developing mental or physical illnesses, positive psychiatry seeks to understand and promote well-being. Numerous studies have shown that optimism, wisdom, creativity, personal mastery, likability, humor, and family/social supports enhance coping and recovery from mental and physical illnesses. Increasing evidence suggests that some of these factors also protect against disorder, stress, and burnout. Research has uncovered a number of positive interventions that enhance well-being and increase positive functioning. These interventions have application in clinical and non-clinical populations. In this course, practitioners will gain a working knowledge of how to apply the science of positive psychiatry in their practice. Topics include the science underlying positive psychiatry, the application of evidence-based positive interventions for those who have or are at risk of developing mental illness, cultivating resilience, and developing positive resources across the lifespan. Practitioners will learn how to help patients build strengths and increase positive emotions, engagement, and meaning in their patients' lives. In addition to expanding the range of treatment options, these tools will help practitioners better engage patients in the treatment process. The focus will be optimizing patients' functioning and helping them find "wellness within the illness." The panel of experts will first discuss the definitions and tools of positive psychiatry (Dr. Jeste), followed by review of preventive interventions in younger adults (Dr. Boardman) and resilience-building interventions in aging adults (Dr. Lavretsky) and in children (Dr. Rettew). The course will be concluded by panel discussion and audience interaction.

Psychiatric Care for Transgender and Gender Non-Conforming (TGNC) Youth and Young Adults

Directors: Shervin Shadianloo, M.D., Ali Maher Haidar, M.D.

Faculty: Richard Randall Pleak, M.D., Sarah E. Herbert, M.D., Jack Lewis Turban, M.D., M.H.S., Alexis Chavez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand gender development and its variance among youth and young adults; 2) Evaluate and provide gender-affirming care for TGNC youth and young adults; 3) Treat co-occurring mental health conditions in TGNC youth and young adults; 4) Advocate for mental health care of TGNC youth and young adults; and 5) Refer TGNC youth and young adults to appropriate services and specialties in their course of transitioning

SUMMARY:

Medical school and residency curricula often minimally address gender development and evidence-based treatment for transgender and gender non-conforming (TGNC) people. Deficiencies in understanding gender development are ubiquitous among most physicians and often lead to missed opportunities to forge alliance with the adult patient. Although various health care organizations have published guidelines or reviewed of the evidence to inform standards of care for transgender individuals, trained physicians often find themselves unprepared and may rely either on social resources or avoid participating in treatment plans altogether. Despite these gaps in knowledge, psychiatrists are often expected by society and by other physicians to be experts on complex social and biological constructs such as gender. There has also been an increase in the number of psychiatrists and other mental health providers treating and helping TGNC adults; however, there are significant deficiencies in practitioners trained in working with adolescents and young adults. TGNC adolescents and children have special developmental needs that often can be missed if the treating team is not familiar with these differences. Adolescents and young adults in particular are increasingly seeking help, and psychiatrists are asked to assist in their management. Treating TGNC youth has been propelled to the forefront of conversation recently with increased attention to this group. Young adults have similar needs to adolescents, and it is

important to understand their family dynamic. Adult psychiatrists are often involved in treating these older adolescents and younger adults. Aside from facilitating transition or referral to other medical specialties, treatment of TGNC youth requires an astute focus by psychiatrists. It is important that the treating psychiatrist understand the special developmental needs of this young population in addition to basic rules of caring and referral for other adult transgender people. Psychiatrists may need to be nonjudgmental advocates who help TGNC youth better articulate their gender identity and walk with them throughout the journey rather than just provide approval for initiation of their transition. This course will provide an overview of the history of diagnosis and the most commonly accepted models of gender development, as well as provide clinical vignettes for TGNC adolescents and young adults coupled with discussions on management. We will address the latest guidelines for managing and evaluating psychiatric concerns in this population, as well as offer latest data on expected coexisting psychiatric conditions.

Psychiatric Disorders in Pregnancy and Postpartum: An Update

*Directors: Shaila Misri, M.D., Deirdre M. Ryan, M.D.
Faculty: Nicole T. Tsang, M.D., Barbara Shulman,
Tricia A. Bowering, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify risk factors for perinatal mood and anxiety disorders and be familiar with individualized treatment interventions; 2) Recognize effects of anxiety on fetus/developing child and to review clinical presentations and treatment options; 3) Understand how perinatal mood/anxiety disorders affect mothers, fathers, and children and learn about nonpharmacological treatment interventions; 4) Understand the impact of untreated maternal illness on fetus, child, and family and recognize evidence-based treatment guidelines, including pharmacological treatments; and 5) Understand the principles of pharmacotherapy in bipolar disorders I and II in perinatal women

SUMMARY:

This updated course provides a comprehensive overview of research updates and current clinical guidelines in major depression, bipolar disorder, and anxiety disorders (GAD, PD, OCD, and PTSD) during pregnancy and the postpartum period. This course looks at new research findings and pharmacotherapy treatment options in bipolar disorder, major depression, anxiety, and ADHD; nonpharmacological treatments (psychotherapies such as mindfulness-based cognitive therapy (MBCT), CBT, and IPT); and mother-baby attachment issues. Management of women with bipolar disorder during pregnancy/postpartum will be covered in detail. Updated research on mood stabilizers and atypical antipsychotics, as well as new FDA warnings for mood stabilizers, will be presented. This course is interactive, and the audience is encouraged to bring forward their complex patient scenarios or case vignettes for discussion. The course handouts are specifically designed to update the audience on the cutting-edge knowledge in this subspecialty. This course will empower the audience to be confident about treating various aspects of pregnancy and postpartum mood disorders. Special attention will be paid to the complexities involved in prescribing psychotropic medications in pregnant and breastfeeding mothers. New research with regard to nonpharmacological options will be discussed in depth.

The Clinical Assessment of Malingered Mental Illness

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Detect clues to malingered psychosis; 2) Identify factors that distinguish genuine from faked hallucinations and genuine from faked delusions; and 3) Be more skillful in detecting deception and malingering, especially in defendants pleading not guilty by reason of insanity

SUMMARY:

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. The latest research on malingered hallucinations will be covered. Psychotic hallucinations will be distinguished from nonpsychotic hallucinations.

Suspect auditory hallucinations are less likely to be associated with delusions. Persons faking auditory hallucinations may say they have no strategies to diminish malevolent voices and claim that all command hallucinations must be obeyed. Malingers are more likely to report extreme severity and intensity of their hallucinations. Suspect visual hallucinations are more likely to be reported in black and white rather than in color, be dramatic, and include miniature or giant figures. Resolution of genuine hallucinations and delusions with antipsychotic treatment will be delineated. Participants will learn 12 clues to detect malingered psychosis and four clues to detect malingered insanity defenses. Videotapes of several defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned hallucinations.

**Treating Narcissistic Personality Disorder:
Transference-Focused Psychotherapy**

Director: Frank Elton Yeomans, M.D., Ph.D.

*Faculty: Otto F. Kernberg, M.D., Eve Caligor, M.D.,
Diana Diamond, Ph.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and appreciate the range and types of narcissistic pathology; 2) Recognize and work with the pathological grandiose self, the psychological structure that underlies the symptoms of narcissistic personality disorder; 3) Acquire treatment techniques that address narcissistic resistances and that help engage the patient in therapy; 4) Acquire treatment techniques that help patient and therapist work with the anxieties beneath the grandiose self; and 5) Work with the typical attachment styles of narcissistic patients

SUMMARY:

Narcissistic disorders are prevalent and can be among the most difficult clinical problems to treat. Narcissistic patients tend to cling to a system of thought that interferes with establishing relations and successfully integrating into the world. Furthermore, these patients can engender powerful countertransference feelings of being incompetent, bored, disparaged, and dismissed or, at the other

extreme, massively and unnervingly idealized. This course will present a framework for conceptualizing, identifying, and treating individuals diagnosed with narcissistic personality disorder (NPD) or with significant narcissistic features. Narcissism encompasses normative strivings for perfection, mastery, and wholeness, as well as pathological and defensive distortions of these strivings. Such pathological distortions may present overtly in the form of grandiosity, exploitation of others, retreat to omnipotence, or denial of dependency, or covertly in the form of self-effacement, inhibition, and chronic, extreme narcissistic vulnerability. Adding to the difficulties in diagnosing and treating narcissistic disorders is the fact that they can manifest themselves in multiple presentations depending on the level of personality organization, subtype, or activated mental state. In this course, we will review the levels of narcissistic pathology. We will go on to discuss a specific theoretical and clinical formulation of narcissism and a manualized psychodynamic psychotherapy, transference-focused psychotherapy (TFP), that has been modified to treat patients with narcissistic disorders. We will review therapeutic modifications that can help clinicians connect with and treat patients with narcissistic pathology at different levels.

Tuesday, May 21, 2019

Evaluation and Treatment of Sexual Dysfunctions

Director: Waquih William IsHak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Acquire practical knowledge and skills in evaluation of sexual dysfunctions; 2) Acquire practical knowledge and skills in treatment of sexual dysfunctions; and 3) Apply gained knowledge/skills to real-world examples of sexual dysfunctions in men and women

SUMMARY:

This course is designed to meet the needs of psychiatrists who are interested in acquiring current knowledge about the evaluation and treatment of sexual disorders in everyday psychiatric practice. Participants will acquire knowledge and skills in taking an adequate sexual history and diagnostic

formulation. The epidemiology, diagnostic criteria, and treatment of different sexual disorders will be presented, including the impact of current psychiatric and nonpsychiatric medications on sexual functioning. Treatment of medication-induced sexual dysfunction (especially the management of SSRI-induced sexual dysfunction), as well as sexual disorders secondary to medical conditions, will be presented. Treatment interventions for sexual disorders will be discussed, including psychotherapeutic and pharmacological treatments. Clinical application of presented material will be provided using real-world case examples brought by the presenter and participants. Methods of teaching will include lectures, clinical vignettes, and group discussions.

Identifying and Helping Older Adults With Mild Neurocognitive Disorder

Director: James Michael Ellison, M.D., M.P.H.

Faculty: Donald Davidoff, Ph.D., David P. Olson, M.D., Ph.D., Jennifer Rose Gatchel, M.D., Ph.D., Regan Patrick

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn to detect and assess DSM-5 mild neurocognitive disorder; 2) Understand the clinical and prognostic significance of MiND, which lies between normal cognitive aging and major neurocognitive disorder; 3) Become familiar with evidence-based interventions that can delay or mitigate cognitive decline; 4) Understand the role of neuropsychological assessment in the evaluation of mild neurocognitive disorder; and 5) Become acquainted with current and evolving neuroimaging techniques used in assessing mild neurocognitive disorder

SUMMARY:

This is an interdisciplinary course developed in order to help clinicians understand the detection, clinical significance, and current evidence-based interventions for people with DSM-5 mild neurocognitive disorder (MiND). Before current biomarker studies, mild cognitive symptoms were often attributed to depression or anxiety. Depression can be a prodrome of cognitive impairment, a risk factor for cognitive decline, a

manifestation of a shared underlying etiology, or a reaction to progressive functional limitation. Identifying which of these paradigms applies can pave the way for effective intervention. Mild age-associated changes in cognition reflect aging of the brain, including changes in synaptic structure, neurotransmitter activity, integrity of white matter, and volume. Many older adults note mild changes in cognitive function and express concern about progression. In “subjective cognitive impairment,” the earliest stage of cognitive impairment to reach awareness, individuals complain of mildly compromised cognitive functioning that falls below the sensitivity of standardized screening tests. Subjective cognitive impairment may be a precursor to MiND. Concerns about memory or other cognitive faculties may lead an older adult to seek evaluation at this stage. MiND is a limited but significant functional impairment associated with an acquired decline in one or more of six cognitive domains: attention, memory, language, visuospatial, executive function, or social cognition. Compensatory behaviors are required to deal with a cognitive decline that is significant but not disabling. New dependence on cueing, reminders, lists, assistive technology such as GPS, or the help of others can signify the presence of mild neurocognitive disorder while allowing the affected person to function with apparent independence. MiND can represent the prodromal stage of major neurocognitive disorder, whether associated with Alzheimer’s disease or another etiology. MiND is linked with biomarker changes, including hippocampal and global brain volume loss, changes in regional glucose metabolism, amyloid deposition, and deposition of amyloid plaques. A growing focus in dementia care is prevention. Thorough assessment of mild cognitive changes in older adults may in some cases help delay progression. Neuropsychological testing and neuroimaging play important assessment roles. Identifiable medical causes of cognitive symptoms, such as dysregulation of glucose metabolism, can sometimes be identified and addressed. Modification of physical activity, diet, cognitive stimulation, social engagement, and sleep quality have each been proposed to improve cognitive functioning or delay decline. While investigation of pharmacological interventions continues, the effect

sizes of these lifestyle factors are being assessed in multiple trials.

Integrating Neuroscience Into the Clinical Practice of Psychiatry: A Hands-on Practicum From the National Neuroscience Curriculum Initiative (NNCI)

Directors: Ashley E. Walker, M.D., Jane Louise Eisen, M.D.

Faculty: Belinda ShenYu Bandstra, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the value of incorporating a neuroscience framework into the everyday clinical practice of psychiatry; 2) Feel confident and empowered that, with or without a neuroscience background, they can integrate cutting-edge neuroscience knowledge in routine clinical settings; and 3) Access and use new and innovative methods to educate patients, relatives, and trainees about clinically relevant neuroscience findings

SUMMARY:

Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry, yet most psychiatrists have relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of access to neuroscience teaching faculty. In addition, neuroscience has generally not been taught in a way that is engaging and accessible. The focus of this course will be on strategies to incorporate a modern neuroscience perspective into clinical care and bring the bench to the bedside. Attendees will participate in new learning activities to further integrate neuroscience into their psychiatric practice in ways that are both accessible and engaging and which encourage lifelong learning. The session will include multiple workshops: 1) **Clinical Neuroscience Conversations**: This session is loosely modeled on the idea of the one-minute preceptor—i.e., neuroscience teaching that can be done in the moment, with minimal preparation, and linked directly to a common clinical scenario; 2)

Progressive Case Conference: In this session, participants will demonstrate practical knowledge of the clinical application and limitations of psychiatric pharmacogenomics data in clinical settings; 3) **Translational Neuroscience**: This session demonstrates how current neuroscience work could change the way we think about treating our patients in the future and allows participants to improve their skills and confidence in reviewing neuroscientific literature.

Integrating Technology and Psychiatry

Director: John Luo, M.D.

Faculty: Carlyle Hung-Lun Chan, M.D., John Torous, M.D., Steven Richard Chan, M.D., M.B.A., Robert Kennedy

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Utilize online resources for lifelong learning, patient care, and collaboration; 2) Integrate electronic practice management tools in education, communication, documentation, screening, and evaluation; 3) Monitor and maintain professional identity and privacy; and 4) Assess novel technologies such as smartphone apps and predictive analytics to determine their role in patient care

SUMMARY:

This course addresses the important aspects of managing information and technology that has become an integral component of the practice of psychiatry and medicine. Finding ways to make technology work both as a means of communication and as a way of keeping up to date on current changes in the field is an important goal. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system, participating in a social network as a career resource, using a smartphone or tablet to connect via email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in health care management, there are many ways and reasons to integrate technology in the practice of psychiatry. This course will review the technology trends, applications, gadgets, and other novel technologies in the future of patient interaction. We

will explore the evolving role of tablets, smartphones, and social media as mediums for clinical practice. This course will explore many of the ways that clinicians can use technology to manage and improve their practice.

Motivational Interviewing: A Stepped-Care Approach to Advanced Skills

Director: Steven Arnold Cole, M.D.

Faculty: Joseph Weiner

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review and explain core MI concepts, including the four phases of MI, the four domains of spirit, and use of OARS to work through ambivalence; 2) Explain step one of advanced skills: respond to distress/dance with discord; 3) Describe step two: respond to sustain talk; 4) Discuss step three: work through ambivalence/develop the discrepancy; and 5) Use four global measures of the MI Treatment Integrity Code (MITI) to assess their own and others' competence

SUMMARY:

Motivational Interviewing (MI), defined as a "collaborative, patient-centered form of guiding to elicit and strengthen motivation for change," has been shown to improve outcomes across multiple health behaviors, including substance abuse, smoking, obesity, and medication nonadherence. MI has also been shown to contribute to improved outcomes when combined with CBT or other psychotherapies. This course on advanced MI, for participants who have MI experience or who have taken an APA course on basic MI, will provide participants with sufficient competencies to begin using MI in clinical practice, especially for patients with persistent unhealthy behaviors. The course will begin with a very rapid review of core MI concepts: four processes, four domains of spirit, ambivalence, OARS+I, and change/sustain talk. Attendees will also review or learn the eight core competencies of Brief Action Planning (BAP), a form of brief MI defined as a highly structured, stepped-care, evidence-informed, self-management support tool and technique based on the principles and practice of MI. Developed by the course facilitator, who is a member of the Motivational Interviewing Network

of Trainers (MINT), with support from three colleagues (all of whom are also members of MINT), research on BAP has been published or presented in numerous peer-reviewed publications and academic conferences and has been disseminated by government agencies and foundations. After the initial brief review, the course will focus on understanding and practicing three stages of a stepped care approach to advanced MI skills: 1) responding to distress and "dancing with discord," 2) responding to sustain talk, and 3) working through ambivalence/developing the discrepancy. Using interactive lectures with power point slides, summary flow sheets, high-definition annotated video demonstrations, and individual and small group exercises, this course will offer participants the opportunity to practice advanced skills in small groups with feedback from the facilitator and colleagues. The facilitator will encourage interactive questions and suggestions to help guide course activities, as well as written terminal assessments to summarize learning, ideas for improvement, and "next learning steps." Finally, this advanced course will also introduce participants to the Motivational Interviewing Treatment Integrity Code (MITI) 4.2.2 and include practice exercises enabling attendees to rate themselves and others on the two relational and two technical global measures of MI competency.

Sleep Issues and Psychiatric Disorders: What Should Mental Health Professionals Know?

Directors: Karim W. Ghobrial-Sedky, M.D., M.Sc.,

Andres Julio Pumariaga, M.D.

Faculty: Racha F. Nazir, M.D., Donna Marie Sudak, M.D., Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and know types of sleep disorders; 2) Appreciate the bidirectional relationship between sleep disorders and psychiatric disorders; 3) Understand the neurobiology of sleep disorders and its overlap with psychiatric disorders; and 4) Articulate the treatment options for sleep disorders (both psychopharmacology and psychotherapy)

SUMMARY:

Over the years, more appreciation has been given to how insomnia or other sleep disorders might affect the outcome of psychiatric syndromes. Although in the past it was thought that treatment of one disorder will resolve the other, more data are evolving to the need of addressing both as separate entities. This course will review types of sleep disorders and how an overlap between sleep and psychiatric disorders is frequent. In addition, a review of studies addressing this overlap will be conducted. Similarly, the neurobiological basis for both disorders will be discussed. Although both psychopharmacological and psychotherapeutic modalities have been often used, the limited knowledge of this modality and accessibility to therapists renders this modality more challenging to use. A review of cognitive behavior therapy for insomnia will be discussed. Similarly, medication effects and classes will be explored. Discussion of sleep disorders in special populations (i.e., veterans, children and adolescents, women [especially pregnant and menopausal], and geriatrics) will be conducted.

These Are the Droids You're Looking for: An Expert Course on QTc, ECG, Psychotropic Medications, and Other Jedi Mind Tricks

Director: Margo Christiane Funk, M.D., M.A.

Faculty: Jolene Bostwick, Pharm.D., Scott R. Beach, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Confidently measure the QT interval, choose the most appropriate correction formula, and calculate the QTc; 2) List medications and common drug interactions that confer high risk of Torsades de Pointes; 3) Correlate components of the 12-lead ECG with cardiac electrophysiological mechanisms; 4) Describe high-yield strategies for various practice settings and populations, including the intensive care unit, substance use disorders, and resource-poor clinics; and 5) Describe an approach to comprehensive risk-benefit analysis in patients who require control of high-risk psychopathology and may be at risk for Torsades de Pointes

SUMMARY:

Psychiatrists routinely prescribe psychotropic drugs that may prolong cardiac repolarization, thereby increasing the risk for Torsades de Pointes (TdP), a potentially fatal cardiac arrhythmia. The corrected QT interval (QTc) on the 12-lead electrocardiogram (ECG) is the most widely accepted benchmark of TdP risk and has drawn significant attention among prescribers of psychotropic medications. Over the past decade, psychiatrists have witnessed the swinging pendulum effect of approaches to QTc prolongation and psychopharmacology, from unwitting disregard to marked hypervigilance. The APA Council on Consultation-Liaison Psychiatry, in collaboration with the American College of Cardiology, convened a workgroup of experts to create a set of clinical considerations for the practicing psychiatrist. Questions addressed by the workgroup included What are the medications that confer risk of TdP? When is it important to monitor the QTc? and How do you balance the potential risk of arrhythmia with the potential risk of failure to control high-risk psychopathology? Central to these considerations is the expectation that basic ECG interpretation is within the scope of a psychiatrist who is ultimately "physician first" and that we should support and empower psychiatrists to feel comfortable enough with the ECG to guide most prescribing decisions. In this experiential course, nationally recognized psychiatry, pharmacy, and cardiology experts will lead participants through an in-depth, evidence-based understanding of QTc prolongation, psychotropic medications, and ECG interpretation. A primer on electrocardiogram (ECG) interpretation will be presented, followed by hands-on practice with measurement of the QTc, appropriate applications for different QTc correction formulae, and an approach to more complex patients, including those with pacemakers and implantable cardioverter defibrillators. A general approach to TdP risk stratification and risk mitigation will be presented, followed by a broad set of interactive clinical cases, which will become increasingly complex as the learner becomes more confident. We will discuss high-yield strategies for various practice settings and populations, including outpatient public and community psychiatry settings, resource-poor clinics, patients with substance use disorders, patients with complex

cardiac disease, and the general hospital and intensive care unit setting.

Wednesday, May 22, 2019

Acute Brain Failure: Pathophysiology, Diagnosis, Management, and Sequelae of Delirium

Director: Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; 2) Recognize the main risk factors for the development of delirium in the clinical setting; 3) Describe the evidence regarding the use of nonpharmacological techniques (e.g., light therapy, early mobilization) in delirium prevention and treatment; 4) Define the evidence behind the use of antipsychotic agents in the prevention and treatment of delirium; and 5) Recognize the evidence behind the use of non-conventional agents (e.g., alpha-2 agonist, melatonin, anticonvulsant agents) in the prevention and treatment of delirium

SUMMARY:

Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity due to disturbances of systemic physiology. It is also the most common psychiatric syndrome found in the general hospital setting, causing widespread adverse impact to medically ill patients. Studies have demonstrated that the occurrence of delirium is associated with greater morbidity, mortality, and a number of short- and long-term problems. Short-term, patients suffering from delirium are at risk of harming themselves (e.g., falls, accidental extubation) and of accidentally injuring their caregivers due to confusion, agitation, and paranoia. Long-term, delirium has been associated with increased hospital-acquired complications (e.g., decubitus ulcers, aspiration pneumonia), a slower rate of physical recovery, prolonged hospital stays, and increased placement in specialized intermediate and long-term care facilities. Furthermore, delirium is associated with poor functional and cognitive recovery, an increased rate of cognitive impairment (including increasing rates of dementia), and

decreased quality of life. This course will review reasons why all psychiatrists must know about delirium; delirium's diagnostic criteria (including new DSM-5 and ICD-10 criteria); delirium subtypes, clinical presentation, and characteristics; the benefits and limitations of available diagnostic tools; the proposed theories regarding its pathogenesis; the reciprocal relationship between delirium and cognitive functioning (both before and after delirium occurrence); and the behavioral and pharmacological, evidence-based techniques associated with successful prevention and treatment strategies. We will also use delirium tremens (i.e., alcohol withdrawal delirium) as a way to better understand delirium's pathophysiology and discuss novel, benzodiazepine-sparing techniques in order to better control the syndrome and prevent its complications while avoiding the deliriogenic effects of benzodiazepine agents.

Autism Update for the Clinician: From Diagnosis to Behavioral and Pharmacological Interventions

Directors: Gagan Joshi, M.D., Roma Vasa, M.D.

Faculty: McLeod Frampton Gwynette, M.D., Bryan H. King, M.D., Rebecca Ann Muhle, M.D., Ph.D., Jeremy Veenstra-VanderWeele, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the diagnostic evolution for autism spectrum disorder (ASD) and the evaluation strategies for arriving at an appropriate diagnosis; 2) Discuss current evidence-based guidelines for genetic testing in ASD; 3) Review the latest evidence for behavioral interventions in ASD across the lifespan with a particular focus on the integration of technology interventions; 4) Appreciate the burden of psychopathology associated with psychiatrically referred populations with ASD; and 5) Demonstrate the unique considerations in recognition and psychopharmacological management of psychopathologies frequently associated with ASD

SUMMARY:

This course fills a professional educational gap by providing an up-to-date, clinically focused research review of diagnostic assessment and management of autism spectrum disorder (ASD) and co-occurring

psychopathology. It is designed for mental health professionals providing clinical care to individuals with ASD and consists of two modules that include presentations pertaining to an overarching theme followed by a panel discussion to address audience questions. Faculty will offer a clinically applicable review and patient vignettes exemplifying challenges in diagnosing and managing ASD and associated psychopathology. ASD is a neurodevelopmental disorder affecting individuals across the lifespan. Higher prevalence of ASD is noted in successive epidemiological CDC surveys, with a latest estimate of 1 in 59 children, leading to a rapidly growing population of adults with ASD. ASD prevalence is notably higher in psychiatrically referred populations and, per the CDC, the risk of underrecognition and delay in the diagnosis of ASD is substantially higher in emotionally disturbed populations. Misattributing ASD features as aberrant psychopathological processes may lead to inappropriate and unnecessary exposure to psychotropics. There is acute need for clinicians to optimize clinical competence in screening and diagnosing ASD in psychiatrically referred populations and in addressing distinctive behavioral challenges associated with the disorder. The first module will focus on the diagnostic assessment and behavioral management of ASD. The initial presentation will review the diagnostic evolution and construct of ASD and present strategies to address diagnostic challenges. It will be followed by a presentation reviewing the role of genetic workup in diagnosing and managing ASD. The module will conclude with a presentation on behavioral interventions and the role of technology in managing ASD. Psychiatrically referred populations with ASD suffer from higher-than-typically-expected levels of psychiatric comorbidity. Until recently, DSM-based diagnostic restrictions precluded recognition of comorbid psychopathologies in the presence of ASD, historically leading to underrecognition of coexisting psychiatric disorders in ASD populations. Presence of psychiatric comorbidity with ASD not only worsens already compromised social functioning, but can also interfere with critical efforts at psychosocial rehabilitation. Proper identification of psychopathology associated with ASD offers opportunity to administer disorder-specific interventions. The second module will focus on

diagnosis and management of psychopathologies often associated with ASD. It will review the burden of psychopathology in ASD and highlight unique considerations for recognition and treatment of psychopathologies in ASD, including ADHD, anxiety disorders, and emotional dysregulation. Clinical case examples will be provided along with step by step guidelines for assessment and treatment.

Disaster Psychiatry Review and Updates: Mass Violence, Climate Change, and Ebola

Director: Joshua C. Morganstein, M.D.

Faculty: James Curtis West Jr., M.D., Robert J. Ursano, M.D., Joseph C. Napoli, M.D., Frederick J. Stoddard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review critical principles in disaster psychiatry, including behavioral and psychological reactions; preparedness, response, and recovery; early interventions; and crisis and risk communication; 2) Discuss the mental health effects of mass violence and disruption, with special consideration of mass shootings in “safe havens,” such as churches, schools, and health care settings; 3) Describe the impacts of climate-related disaster events on human health and how to apply critical principles in disaster psychiatry to enhance community preparedness and resilience; and 4) Understand unique psychological and behavioral responses to pandemics and important aspects of preparation and response to these events using contemporary media content

SUMMARY:

Natural disasters and mass violence are occurring with increased frequency around the world. While many people manifest resilience, a sizable number of those affected experience adverse behavioral and psychological effects. Distress responses, health risk behaviors, and psychiatric disorders produce significant morbidity and mortality. Early interventions, such as psychological first aid, may reduce individual and community distress. Effective health risk and crisis communication is a critical population health intervention following disaster to build trust and enhance collaboration with the public. Certain populations are particularly

vulnerable to adverse mental health effects of disaster events; awareness of these vulnerable populations allows for focused behavioral health interventions. Those leading disaster management efforts provide a critical role in restoring community well-being; consultation and support to leaders can be an important intervention in sustaining their effectiveness and optimizing overall response efforts. The course will review these important principles, enabling attendees to more effectively prepare for and respond to disasters through support of their patients and wider communities. Mass shootings, climate-related natural disasters, and pandemics are significant global health threats generating increased attention in the United States and throughout the international community. The concert shootings in Las Vegas, high school shootings in Florida, and bombings at the concert and subway in the UK are among a growing list of increasingly frequent episodes of mass violence. Mass killing and disruption are well-established elements of terrorism that cause unique psychological effects. Hurricanes in Puerto Rico and Texas and Florida, wildfires in California and Canada, and floods in South Asia and Sri Lanka are recent climate-related disasters that resulted in significant injury, death, and economic costs. These extreme and slow-moving weather events are occurring with increasing frequency and severity around the globe. Risk perception regarding climate change and belief in the ability to effect change are important factors in decision-making regarding climate change-related behaviors. Pandemic infectious diseases and other disasters involving exposure and contamination result in unique fear-based responses exacerbated by requirements for isolation and quarantine. This course begins with a review of fundamental principles in disaster mental health. Using case examples and accompanying media content drawn from contemporary disaster events, attendees will participate in interactive application of those principles applied to mass violence, climate change, and pandemics. The audience will be engaged throughout the course using small group exercises, polling questions, and mobile smartphone apps.

Focus Lives

Tuesday, May 21, 2019

Focus Live: Complementary and Integrative Medicine

Moderator: Mark Hyman Rapaport, M.D.

Presenter: David Mischoulon, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review a selection of some of the more commonly used and better studied complementary and alternative medicine (CAM) interventions that have applications in psychiatry; 2) Be better able to make educated decisions in the clinical setting and to answer a patient's questions in a practical way about complementary and integrative medicine; and 3) Review current knowledge, recognize gaps in learning, and identify areas where more study is needed to enhance management of patients' treatment

SUMMARY:

Complementary and integrative (or alternative) medicine (CAM), despite its popularity, remains largely a mystery, psychiatric symptoms represent one of the most common reasons for the use of CAM. Yet, despite the growing popularity of complementary therapies, their efficacy and safety are not as well characterized compared with registered medications, largely because of relatively fewer large-scale controlled clinical trials. Likewise, education about CAM during medical training is scanty, both at graduate and postgraduate training levels. Important questions remain unanswered, such as whether these treatments are more effective than placebos or are comparable to therapies approved by the U.S. Food and Drug Administration, as well as whether they may harbor any risks of short-or long-term harm. This multiple-choice question-based presentation highlights a selection of some of the more commonly used and better studied CAM interventions that have applications in psychiatry, presenting a selection of therapies to convey the breadth of possibilities that CAM offers in the world of psychiatry. Including popular herbal and natural products for mood, anxiety, and cognition, yoga as an integrative treatment, mindfulness-based cognitive therapy and meditation in psychiatry, and applications of Tai-Chi and Qi Gong for mood regulation. This FOCUS LIVE presentation will present multiple choice questions

based on information about the current status of our assessment and treatment approaches for CAM interventions and will provide participants with an opportunity to test their knowledge about this disorder.

Focus Live: Emerging Therapies in Psychiatry

Moderator: Mark Hyman Rapaport, M.D.

Presenter: Ian A. Cook, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the theory behind ketamine and related medications for use in depression, the elements of the pharmacology of ketamine, and important risks and precautions; 2) Understand uses of virtual reality in clinical practice and other emerging therapies with clinical applications and developments in computer technologies for mental health; and 3) Review current knowledge, recognize gaps in learning, and identify areas where more study is needed to enhance management of patients' treatment

SUMMARY:

Recent years have seen the development of new therapeutics for psychiatric patients, including new approaches to psychotherapy, new medications, and new neuromodulation methods. These innovations are all driven by unmet patient needs in efficacy, tolerability, treatment burden, and preference. The monoamine-based hypotheses of mood disorders that informed development of many medications from the 1960s onward are now sharing the spotlight with theories based on other neurotransmitter systems. Theories involving glutamate and the brain's response to chronic stress have been supported by in vitro, preclinical animal, and clinical human studies. In particular, agents that can influence glutamatergic neurotransmission via either the N-methyl-D-aspartate (NMDA) or the amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) receptors have gained considerable attention. Early studies using the agent ketamine as a rapidly acting antidepressant for humans have gained traction in both clinical practice and in the development of alternative agents with similar effects. Developments in computer-related technologies have fueled the rise of virtual reality

(VR) and augmented reality (AR) tools that can place a user in an immersive environment so that sight, sound, and vibrational cues all reinforce the experience that the user is in another place and time. Improvements in hardware and software have enabled the experience to become increasingly similar to real life, allowing the illusion to be much more real and powerful. The growth of mobile computing also has taken on important uses in mental health. The application of digital technologies—frequently available anywhere at any time—have great potential to improve care. Whether in developing improved diagnostic approaches, implementing measurement-based methods to evaluate response to treatment, or providing online forms of psychotherapy to patients when it is most convenient to them, there are many places where digital technology is likely to have an increasing impact. With medication treatment, mechanisms of action are presumed to be tied to events happening primarily inside the brain. In contrast, other treatment approaches have sought to utilize alternative pathways to modulate brain-based events such as neuromodulation. This FOCUS LIVE presentation will present multiple choice questions based on information about emerging therapies and will provide participants with an opportunity to test their knowledge and learn about these treatments.

General Sessions

Saturday, May 18, 2019

#Actuallyborderline: What Psychiatrists Can Learn From Social Media Posts of Individuals With Self-Identified Borderline Personality Disorder

Chair: Michael John Gower, M.D.

Presenters: Virmarie Diaz Fernandez, M.D., Sean V. Thomas, M.D., Tomi Rumano, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the typical kinds of social media posts identified as related to BPD and how these are reflective of specific symptoms and therapeutic needs affecting individuals with BPD.; 2) Understand the function of social media posting by individuals with mental illness, and BPD particularly, as a means of eliciting peer support, validation of

suffering, and/or catharsis.; 3) Identify at least two aspects of BPD prominent in social media postings which are not typically discussed with treating providers.; 4) Identify multiple positive and negative effects for patients of social media communities based on sharing of symptoms.; and 5) Describe specific strategies for improving therapeutic communications with patients with BPD based on knowledge from social media communities.

SUMMARY:

Borderline personality disorder (BPD) is an often-stigmatized diagnosis. However many individuals find the simple fact of having a diagnosis therapeutic in that it identifies a source and explanation for their symptoms and can be a validation of their suffering. However, over-identification with a mental illness diagnosis may be problematic, as individuals may exaggerate symptoms or even model their behavior to better exemplify a diagnosis in order to obtain sympathy and recognition of their pain. For many young people, social media is an important avenue for commiserating and obtaining support from peers, especially for those with social anxiety, difficulty with face-to-face interpersonal relationships, or isolating depression. Communities centered around mental illness have developed on popular social media sites, consisting of individuals self-identifying as having BPD, autism, or other diagnoses sharing posts about their struggles and symptoms. These individuals' understanding of their own suffering is informed by their understanding of the psychiatric profession's description of the illness (i.e. DSM criteria) but interestingly, some of the core components of their experience as they define it through social media posts are not captured in DSM criteria. This session will present representative samples of public social media posts by individuals self-identifying as having BPD from sites popular social media sites, describing and categorizing common themes. Particular attention will be paid to oft-described symptoms or phenomena which are not included in DSM criteria for BPD or in common psychiatric formulations of BPD. Discussion will focus on how patients may emphasize different topics in communications with peers versus mental health professionals, evince preferences for certain types of communications, and how treaters can further their understanding of individuals with BPD and improve

therapeutic interactions through knowledge gained from social media communities. Participants will also discuss the function of social media posting for patients as a form of peer-to-peer support and means of validation, as well as the potentially harmful effects of social media environments based on sharing of symptoms, potentially encouraging expressions of pathology. Participants will break into small groups for guided discussion of sample social media posts illustrative of how individuals who identify as having BPD use social media in both constructive and counter-productive ways. In the small groups participants will discuss specific therapeutic interventions for patients described in the posts and will share these with the group as a whole.

#Boundaryviolation: Social Media Use, the Online Relationship Between Patient and Provider, and the Future of Digital Suicide Risk Assessment

Chair: Shruti Mutalik

Presenters: Maria E. Aguilar, M.D., Robert J.

DiFilippo, D.O., Ioana Maria Horotan-Enescu, D.O.,

James William Alewine, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore the various ways in which patients use social media and the underlying psychodynamics driving the same.; 2) Examine what is known about the effect of social media use on mental health.; 3) Discuss existing protocols for responding to patients who reach out to providers online, as well as concerns and considerations for developing protocols in the future.; 4) Explore the phenomenon of "catfishing" and how it could impact the provider-patient relationship.; and 5) Understand the relationship between social media posts and suicide risk assessments.

SUMMARY:

The past few years have seen an exponential increase in the number of social media platforms, ranging from websites that allow for the exchange of information and personal photographs, to programs and applications for the sharing of gaming accomplishments. Studies examining the effect of social media on mental health have had mixed results. Some studies reveal that Internet use can

exacerbate and promote self-injurious behavior. Others have revealed that certain groups benefit from the use of social media, specifically retirees who appear to utilize social media for remaining engaged in the community when otherwise isolated or immobile. Providers will need to understand how to navigate and appreciate the role social media plays in their patient's lives and what it tells us about their sense of self-worth and identity. Due to the ubiquitous use of social media, it is not surprising that providers may also have an appreciable online presence. For some practitioners, social media use predates their engagement in the mental health profession. The challenge is how to address and use therapeutically patients searching and reaching out to their providers via social media applications. We plan to discuss the formal guidelines of how to appropriately respond to online requests for "friends" or "follows", and explore the considerations for protocols that may be developed in the future. We discuss the phenomenon of "catfishing" and how it has impacted, or may impact, the relationship between mental health providers and their patients. Finally, we will examine a consistent theme throughout these platforms: the ability to create a curated online representation of one's life. From a behavioral health perspective, people can use social media as a means to gain attention or empathy during a time of crisis. As such, we hope to examine and discuss how providers can use the chosen language of social media posts as a risk assessment for patients considering suicide or self-injurious behavior.

A Cognitive Behavioral Approach to Weight Loss and Maintenance

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Teach dieters specific "predieting" cognitive and behavioral skills.; 2) Keep motivation high long-term.; and 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 et al, 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.

Academia Meets the Opioid Epidemic: A Complex Journey

Chair: Jonathan Avery, M.D.

Presenters: Mary Hanrahan, Matt DeMasi, Ryan Edward Lawrence, M.D.

Discussant: Bruce Jan Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current evidence-base on best practices to address the opioid epidemic in academia and major medical centers; 2) Delineate the benefits and challenges of implementing different educational and treatment initiatives for opioid use with community collaborators.; and 3) Utilize information from this

session to enhance training and treatment initiatives focused on the opioid epidemic

SUMMARY:

The importance of meeting current standards –of – care to address the opioid epidemic and opioid use disorder (OUD) is a given in any response to the epidemic. Focus should be on preventing over-prescribing of opioids, medication-assisted treatment (MAT) with buprenorphine, methadone, or naltrexone, contingency management, harm-reduction, and preventive measures against overdose deaths. It is imperative that academic and medical centers educate multi-disciplinary staff at all levels about the best standards-of-care available and implement it to the best of their abilities. Here, we describe the efforts of New York Presbyterian, as they work closely with the New York City Department of Health and targeted community providers to combat the stigma of addiction, curb opioid prescribing through different educational and monitoring strategies, and increase availability and knowledge of MAT. Distribution of and education about naloxone rescue kits to a wide audience and other treatment options will be presented as will a discussion of interventions and data on our efforts. We address the importance of community partners with diversified levels of care and the need for an ongoing network of care with the goal of improved care and enhanced outcomes for patients. The successes and challenges faced throughout this process will be explored. Future directions at our medical center and for academia in general will be addressed. Audience participation is welcome in opening a dialogue on best practices in New York and throughout the Behavioral Health community.

Advanced Telepsychiatry Case Dilemmas Roundtable: Navigating Common and Complex Challenges in Clinical Telepsychiatry

Chair: James H. Shore, M.D.

Presenters: Peter M. Yellowlees, M.D., Steven Richard Chan, M.D., M.B.A., Robert Lee Caudill, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1) At the end of this session, participants will understand common clinical challenges that arise during the course of providing

telepsychiatry services.; 2) 2) Participants will understand best practices in addressing clinical issues in telepsychiatry, including managing emergencies, boundaries, prescribing and working as part of a blended team.; and 3) 3) Participants will understand the state of the evidence supporting clinical decision making in telepsychiatry.

SUMMARY:

Telepsychiatry, in the form of live interactive video-conferencing, is becoming a widespread practice that helps to expand the reach of treatment. Providers continue to grow their use of telepsychiatry in an ever-expanding range of settings and models. Although the field has a growing and strong evidence base, clinicians often encounter clinical challenges in dilemmas unique to this modality. This roundtable brings together a panel of national experts in the field of telepsychiatry to present and discuss with the audience the common issues that arise during the provision of clinical telepsychiatric services. This discussion is intended for audience members with some general knowledge of the field of telepsychiatry, including major regulatory and administrative issues. The roundtable will begin with an introduction to the session and the panel, followed by four case presentations, concluding with a final audience panel Q&A discussion and wrap up. Each case presentation will consist of a stimulus video showing a psychiatrist-patient telepsychiatric interaction highlighting a specific dilemma in clinical telepsychiatry. After each case, the roundtable will guide the audience in a discussion of the highlighted issue, discuss controversies, associated scientific literature, case guidance as shaped by the APA/ATA Best Practice recommendations, and debate best clinical management. The areas to be covered in these cases will include: 1) Managing mental health emergencies over distances; 2) Dealing with patient boundaries in home or other unsupervised clinical settings; 3) Prescribing over distances; 4) Attending to managing a virtual/hybrid doctor-patient relationship; 5) Working as part of a blended clinical team (merging remote and on-site team members) and 6) Attending to the impact of patients' environments on clinical treatment. At the conclusion of the session, audience members will have increased their understanding of these

important clinical issues in telepsychiatry, best practices and evidence supporting their management and pragmatic suggestions on how best to attend to and navigate these issues during clinical interactions.

Advocacy 101: Your Road Map to Getting Involved in State Legislative Advocacy

Chair: Maria Mirabela Bodic, M.D.

Presenters: Erin Philp, John J. Sobotka, M.D., Tim Clement, Debra E. Koss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Recognize the importance of legislative advocacy for the mental health care delivery system; 2) 2. Be aware of the resources and support offered by the APA State Government Relations Department and Council on Advocacy and Government Relations; and 3) 3. Identify 3 ways to get involved in legislative advocacy at the local and state level.

SUMMARY:

The overwhelming majority of psychiatrists are not aware of the legislative initiatives happening at the state or federal level, and even fewer are involved in the process at all. On occasion, proposals drafted without the input of the physicians or the patients they will impact fall short of ideal and cause increased burdens on clinicians and difficulties in navigating the healthcare service delivery maze for consumers. Therefore, involvement of psychiatrists in the legislative process is of tremendous importance in the development of a fair and equitable system. Additionally, as respected medical professionals, the targeted support of psychiatrists can sway legislators to support or oppose a piece of legislation. Legislative advocacy sounds like a daunting task and might be viewed as only relevant if done at a high level, but we hope to take our audience through the myriad of ways, big and small, one can make a difference in the process, from signing a letter to your representatives, to providing testimony, to drafting pieces of legislation. Time constraints are also a barrier in further involvement, though studies looking at burnout showed, paradoxically that being involved in your professional organization and in meaningful

professional initiatives outside of the work space actually decrease burnout and increase job satisfaction and feelings of accomplishment. The State Government Relations team at the APA will provide an introductory training of effective methods in legislative advocacy, including how to approach legislators, how to speak to them, and which legislators to target. Then, a small group activity will prompt the audience to choose a major legislative issue in their area and discuss potential ways to get involved at different levels of government. The members of the panel will join each small group and moderate the discussion. We will then discuss the ideas with the entire audience, role play interactions between legislators or legislative staff and physicians advocating on a particular issue, provide insight into the feasibility of the proposed actions, and suggest resources accessible for each area. We hope this joint initiative between APA staff, the council, district branches representatives and membership will lead to establishing fruitful connections and provide interested audience members with a starting point to get involved in legislative advocacy at their state level.

Beyond the Initial Successful Treatment of Anxiety Disorders With Antidepressants: Evidence and Pitfalls for Clinical Practice

Chair: Neeltje Batelaan

Presenters: Renske Bosman, Willemijn Scholten, Anton A. Van Balkom, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Inform patients about pitfalls associated with long-term antidepressant use in clinical practice; 2) Interpret relapse rates after continuation and discontinuation of antidepressants and can discuss these with patients when initiating pharmacological treatment; 3) Identify motivations and barriers of patients and general practitioners to continue or discontinue antidepressants, and the discrepancies between them; 4) Discuss the effectiveness of group cognitive behavioural therapy with patients as a relapse prevention programme in remitted anxiety patients who discontinued antidepressants; and 5) Discuss evidence for

response failure following reinstatement of a previously effective antidepressant

SUMMARY:

Anxiety disorders often have a chronic course and relapse and recurrence after remission is common. When combined with high prevalence rates and functional limitations, anxiety disorders score high on burden of disease rankings. It is therefore important that treatment does not merely focus on the initial (short-term) outcomes, but aims to optimise the long-term course. Like cognitive behavioural therapy, antidepressants are a first line treatment for anxiety disorders, as they are effective and often well tolerated. Antidepressants are frequently used long-term: for example in the USA approximately two-thirds of patients taking antidepressants take them for more than two years and in Europe this is true for nearly half of relevant patients. This is however contrary to the advice of the international treatment guidelines, which recommend discontinuation of antidepressants six to twenty-four months after remission of the anxiety disorder. Many anxiety patients do thus use antidepressants for a prolonged time after initial treatment. Problematic is that treatment guidelines are consensus-based and that there are no clear-cut long-term treatment recommendations for patients who achieved remission whilst using antidepressants. Relevant questions for clinical practice are for example whether antidepressants should be discontinued following remission or not, and if so when should they be discontinued and under which conditions. In this symposium evidence and potential pitfalls of long-term strategies will be discussed along with potential pitfalls. First the question will be raised whether long-term continuation of antidepressants should be considered a strategy to optimise the long-term prognosis of anxiety disorders based on meta-analytic results. Second, the views of patients with anxiety and/or depressive disorder(s) and their general practitioners on long-term antidepressant use, continuation and discontinuation, and discrepancies between them will be presented. Third, the results of a randomized controlled trial investigating the efficacy of a group cognitive behavioural therapy relapse prevention programme for remitted anxiety disorder patients who

discontinued antidepressant will be discussed along with clinical lessons learned from this trial. The symposium will be concluded by discussing the assumption that a previously effective antidepressant is similarly effective again when reinstated following relapse and which evidence is currently available for response failure following reinstatement based on a systematic literature review.

Binge Eating in Bipolar Disorder: A Clinically Severe Phenotype With Important Treatment Implications

Chair: Joel Yager, M.D.

Presenters: Alfredo Bernardo Cuellar-Barboza, Susan Lynn McElroy, M.D., William Victor Bobo, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify binge eating as a common clinical trait associated with higher severity in bipolar disorder; 2) Discuss the genetic implications of binge eating in bipolar patients and the potential neurobiological mechanisms identified by genetic studies; 3) Discuss the long-term metabolic effects of lithium and quetiapine in bipolar patients; 4) Recognize binge eating as a predictor of weight gain in people receiving bipolar disorder medication; and 5) Develop a clinical decision tree for patients with bipolar disorder and comorbid binge eating, with or without obesity

SUMMARY:

Binge eating (BE) is a common phenomenon in bipolar disorder (BD) with considerable clinical implications (1). However, eating disorders rarely take a central stage in the clinical exploration and decision making of mood disorder patients. The aim of this session is to update the audience on the critical role of BE in BD, and moreover, to show the clinician a way of incorporating this knowledge to their everyday practice. BE has been reported to occur in over 25% of individuals with BD (2). Both disorders show high heritability, and BD patients with BE show greater psychiatric comorbidity and worse outcomes, regardless of obesity (1). The clinical impact of BE with and without obesity in BD will be first highlighted from our epidemiological studies. We will discuss the clinical relevance of

understanding genetic risk of complex mental health disorders. We will show the findings of a meta-analysis of two genome-wide association studies of two independent populations of BD patients, where BD with BE shows a distinct genetic risk (3). Common BD medication like lithium and quetiapine can cause weight gain, but their comparative longer term anthropometric effects are unknown. The potential moderating effects of baseline BE behavior on body weight gain and changes in body mass index (BMI) and waist circumference in bipolar adults who received 6 months of treatment with lithium or quetiapine will be discussed. The quetiapine group experienced greater increases in body weight, BMI, and waist circumference. The largest increases in these measures occurred in patients that satisfied a simple definition of baseline BE behavior. The impact of BE on the overall cardiometabolic risk profiles of patients with bipolar disorders and the clinical implications of the findings from this study will be reviewed. Finally, the clinical management of three important and overlapping BD phenotypes will be discussed: BD with BE, BD with obesity, and BD with psychotropic-induced weight gain (4). Since no randomized controlled trials have been done in BD with BE we will first present a brief overview of the psychological and medical treatment of BE. We will then review RCTs of behavioral weight loss interventions and in BD individuals with obesity. Since no RCTs have been done in BD with obesity, we will review drugs approved for chronic weight management and their psychological side effect profiles. We will then briefly review agents studied for psychotropic induced weight gain in populations with BD. We will conclude by presenting an ongoing study of the weight loss drug glucagon-like peptide 1 agonist liraglutide 3mg/d in overweight or obese BD patients who may or may not have comorbid BE. During this session the audience is invited to freely discuss the most challenging clinical scenarios that arise in this population. BE behavior with or without obesity, is expected to take an important role in the clinical exploration, conceptualization and management of BD patients

Brain Changers: Integration and Differentiation of PTSD and TBI in Clinical and Disability Evaluations
Chair: Brandon Withers, M.D.

Presenters: Jeffrey P. Guina, M.D., Keith A. Caruso, M.D., Elspeth Cameron Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Formulate important similarities and differences between Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI); 2) Integrate tools and techniques clinicians can utilize to improve diagnostic accuracy and clarity, especially in a high-risk subset of patients; 3) Describe the potential disability benefit implications of making one diagnosis versus the other, in the military vs. private disability insurance settings; and 4) Apply practice guidelines and research findings in an innovative discussion about treatment options available for implementation in patients diagnosed with PTSD and/or TBI

SUMMARY:

TBI or not TBI? That is the question. As the number of veterans returning from deployments increases, so does the burden of their mental health concerns. The frequent attacks on coalition forces and civilian with improvised explosive devices (IED's) during the conflicts in Iraq and Afghanistan resulted in numerous posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) casualties among military service members. Clinicians in the military and Veterans Affairs (VA) have been challenged by the evaluation of these comorbid conditions. Various issues contribute to diagnostic ambiguity. Chief among these issues is the significant overlap of symptoms shared by both conditions. In fact, one often screens positive on tools designed for the other. To further complicate matters, there are notable differences in disability compensation for each condition within and between VA and private settings. This necessitates that evaluators take care to ensure diagnostic accuracy, including entertaining an appropriate level of suspicion for malingering. Fortunately, there are resources available to help evaluators address these concerns such that more confident and accurate diagnosis and treatment are more likely. Our session will emphasize the key features of each condition, including the pathophysiology, expected course of illness and profiles on neuropsychological testing. We will also compare and contrast the features of both

conditions. Furthermore, we will offer suggestions for additional testing to augment clinical decision-making and to address concerns for malingering. We will discuss specific differences in potential disability benefits provided for each condition. During our session, we will also discuss the varied treatment options for both conditions as well as comorbid conditions that may impact treatment outcomes. The discussants, all current or former military psychiatrists, will bring their experience with the VA system and private disability insurance industry and lead an interactive discussion of the various issues from these differing points of view. We aim to engage the audience in the discussion by using fresh, new, interactive technology that allows for participation in an open, yet low-pressure style.

CBT for Suicidal Behavior

Chair: Donna Marie Sudak, M.D.

Presenters: Judith Beck, Ph.D., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Assess and modify hopelessness and suicidal thinking with CBT principles; 2) 2. Describe research that supports CBT for reducing suicide risk; and 3) 3.

Implement CBT-oriented safety plans with at-risk patients

SUMMARY:

Suicide is the 10th leading cause of death in the United States (2016). CBT approaches to the suicidal patient have been proven to reduce rates of future attempts (Brown et al 2005; Tarrrier et al 2008). Active and collaborative work to reduce hopelessness and specific anti-suicide plans are important features of this approach to patients. This workshop will briefly review research on CBT for treating suicidal patients. The central features of CBT methods for suicide risk will be demonstrated. Role-play demonstrations will illustrate key points. Particular attention will be paid to development of the CBT elements of a safety plan in a depressed patient.

Choosing the Right Treatment for Substance Use Disorders

Chairs: Edward Vernon Nunes, Frances Rudnick Levin, M.D.

Presenters: John J. Mariani, M.D., Adam M. Bisaga, M.D., Elias Dakwar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize clinical signs/symptoms of abuse of sedative-hypnotic or stimulant medications, understand strategies to manage patients, and recognize risks/benefits of prescribing these medications.; 2) Be familiar with medication-assisted treatments for opioid dependence, new approaches to medication induction and discontinuation, and strategies for transitioning patients between treatments.; 3) Be familiar with research findings on the use of pharmacotherapies in combination with behavioral interventions for the treatment of problematic non-prescription stimulant use.; 4) Understand impact of increased marijuana potency and availability and the subsequent need for improved treatments and become aware of treatments trials of pharmacological and psychological approaches.; and 5) Understand major empirically supported behavioral treatments for substance use disorders, potential for combining behavioral and pharmacologic approaches, and obstacles in delivering these treatments.

SUMMARY:

Substance use disorders remain a major public health problem with financial costs and implications for health and criminal justice systems. Shifts continue to occur in cost, purity, and geographic spread of various agents. The fastest growing problem is the rise in heroin use (eg., in New York City, the heroin overdose death rate is the highest that it has been since 2003). In addition, cocaine use remains endemic, methamphetamine use has decreased, marijuana has a higher potency and greater availability, and marijuana use has lower age of onset. The symposium combines current scientific knowledge with discussion of the most effective treatments for all of these agents. Emphasis is on office-based, and presentations include discussion of both pharmacological and psychological treatment methods. The speakers are nationally recognized

experts in substance use disorders and will discuss practical and cutting edge treatments.

Climate Psychiatry 101: What Every Psychiatrist Should Know

Chair: Anne Shelton Richardson, M.D.

Presenters: Robin Julia Cooper, M.D., Elizabeth Haase, M.D., Janet Lisa Lewis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify four mental health implications of climate change; 2) Describe the trends in Acute Stress Disorder, PTSD, depression and suicide in populations affected by climate instability; 3) Identify four impacts of extreme heat and particular impacts of heat for psychiatric patients; 4) Identify three impacts of air pollution on neuropsychiatric functioning; and 5) Describe three reported “psychoterratic syndromes”

SUMMARY:

The warming of our earth has led to multiple geophysical changes that include more extreme weather, intense heat, floods, droughts, fires, ocean acidification, air pollution and extinction at alarming rates. The physical human health impacts might initially be more obvious, but the mental health impacts are present today and striking. In this discussion, we will provide an overview of pertinent topics at the interface of psychiatry and climate change, exploring how our patients are affected by this unnatural phenomenon. There are increasing bodies of evidence that correlate our changing climate to increasing incidence of acute and chronic emotional distress and illness. Psychiatric patients, by virtue of their illnesses, socioeconomic status and medications often possess particular vulnerabilities to climate change. In this interactive presentation we will together explore relationships between heat and aggression, violence, mental health emergencies and suicide. We will review the impacts of air pollution on neuropsychiatric disorders such as developmental disorders and dementia and this relationship to climate change. The majority of Americans are now worried about climate change and, while that worry is generally not pathological, it can present in clinically significant ways. We will define recently emerging terms in the field such as

ecoanxiety, “nature deficit disorder” and solastalgia and the ways they present clinically. We will conclude with an interactive discussion of the recommended interventions at the individual, clinical and public health levels.

Comprehensive Mental Health Care of the Transgender Patient

Chair: Murat I. Altinay, M.D.

*Presenters: Jason V. Lambrese, M.D., Antone Feo
Discussant: Eric Yarbrough, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will familiarize themselves with the biological aspects of gender development, mechanisms underlying gender dysphoria, and current research in transgender mental health.; 2) Participants will understand the clinical psychiatric approach for evaluating adult transgender patients.; 3) Participants will understand the clinical psychiatric approach for evaluating gender nonconforming children and adolescents.; and 4) Participants will understand psychotherapeutic approaches and challenges in the adult transgender population.

SUMMARY:

Mental health management remains the cornerstone of routine and transition-related care of the transgender patient. Despite the recent progress in visibility and acceptance, transgender mental health is still not fully understood or widely studied. In this panel, we will examine this topic from three different angles: 1) Current research and understanding of Gender Dysphoria (GD) and the care of adult transgender patients, 2) Assessment and care of gender nonconforming children and adolescents and 3) Psychological assessment and treatment of transgender patients. The first section will provide an overview of gender identity development, review the biological and neuroimaging findings in the transgender population, and consider the mechanisms that underlie GD in light of past and current research. We will then discuss the assessment of an adult transgender patient with GD in an outpatient setting. The importance of comorbid mood and anxiety disorders and ways to differentiate between

mood disorders and GD will be discussed. We will talk about challenges in making the decision to move forward with medical and surgical transition versus slowing down the process for a healthier transition, as well as the psychiatrist's unique role in orchestrating the care of the transition without assuming a paternalistic approach. This section will also present the approach of an adult psychiatrist in specific history taking; as well as the similarities and differences in the diagnostic criteria in children and adolescents/adults. The second section will review the clinical assessment process across the age span, including a discussion of unique issues pertinent to child & adolescent populations: Gender non-conforming behaviors at a young age, Gender Dysphoria, and possible medical interventions. The importance of puberty in gender identity development is related to the notion that many gender non-conforming children will not be transgender in adolescence and adulthood. We will present an approach to history taking that considers the young person's developmental course, longitudinal gender-related trajectory, cognitive maturity, future transition plans, and support system in determining the diagnosis and treatment plan. Treatment issues specific to the child & adolescent population will be considered. We will share the overall process by which we assess and treat transgender and gender non-conforming adolescents within our academic center's multidisciplinary team. In the last presentation section, we will focus on psychotherapy in the transgender population, including the intake process and the most common problems transgender patients present with, from a psychotherapy standpoint. We will then talk about the specific psychotherapeutic approaches used in therapy tailored specifically for the transgender population, as well as the clinical and administrative challenges in providing psychotherapy for these patients.

Computers and Psychiatry: How Might Our Practice Change?

Chair: Cheryl Corcoran

*Presenters: Justin Taylor Baker, M.D., Ph.D.,
Guillermo Cecchi*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how computer-based analysis of language has enhanced prediction and diagnosis; 2) Discuss computer modeling of therapeutic dialogue to learn; and 3) Describe computational phenotyping and its future in psychiatry

SUMMARY:

There is an ongoing revolution in computational behavioral analysis in business and government. Automated analysis of text is used to screen job applicants and score essays, and is applied to social media to influence individuals' purchasing and voting choices. Automated face and emotion recognition is used for both surveillance and to supplement polygraph testing. Wearables are used to collect physiological data from athletes and astronauts, and increasingly for medical purposes. Only recently have these computational approaches been applied in psychiatry to study disturbances in thought, emotion, and behavior, which traditionally have been assessed using only expert human appraisal, codified in standardized interviews and ratings, but labor-intensive and error-prone. We will review the role of computers in assessment of language and behavior (and in optimizing therapy) in psychiatry, historically, at present, and going forward, in both research and clinical practice. Dr. Cheryl Corcoran will describe how automated analysis of language works, and how it has been used to discriminate among states of intoxication, and also characterize and predict psychosis. Intoxication with Ecstasy is characterized by use of affiliative words, whereas intoxication with methamphetamine is not, instead characterized by increased rate of speaking: this can be captured by computer analysis. Among youths at risk for psychosis, decrease in semantic coherence and syntactic complexity predict psychosis onset, an effect found in two independent at-risk cohorts. Bizarreness and increased metaphor usage is also characteristic of psychosis risk, analyzed using natural language processing, which will be described clearly in lay terms. Focusing on psychotherapy itself, Dr. Guillermo Cecchi of IBM will propose a machine-learning framework for therapeutic dialogue modeling such that abstract representations of pairings of patient's and

therapist's interventions are learned, and used to predict therapist's responses. He will discuss how this approach might be used in the context of outcome-labeled sessions to learn best practices, and how these in turn could be used as a tool to expand the knowledge base of therapists, both "offline" and during ongoing sessions. Dr. Justin Baker will discuss how computational analysis of voice and face expression can inform diagnosis and evaluation, along with what is collected from smart phones. The phones in our pockets provide complex longitudinal in vivo data, much of it passively obtained, including spatial trajectories (GPS), physical movement, and sleep (accelerometer), and social networks and dynamics (phone communication logs). Smartphones can record sleep patterns, respiration, and heart rate variability. Physiological data, with language and facial data, can provide accurate and nuanced real-time readout, and lead to deep phenotyping that can be integrated with genetics and neuroimaging. Margaret Chen, a student in Strategic Design and Management at the Parsons School of Design, will discuss participatory design and end-user development relevant to the use of apps and social media relevant to psychiatry. Ethics will also be discussed.

Creating and Implementing a Program for the Mental Health and Well-Being of Medical Students and Trainees: The Mount Sinai Health System Experience

Chairs: Paul J. Rosenfield, M.D., Jeffrey H. Newcorn, M.D.

Presenters: Sabina Lim, M.D., M.P.H., Daniel S. Safin, M.D., Jonathan Ripp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify purpose and goals of training psychiatrists in community psychiatry; 2) Learn about creating, structuring, financing, operationalizing and scaling up a program to support the wellbeing and mental health of trainees, and how to overcome challenges faced in this process; and 3) Utilize the Mount Sinai Health System's creation of a comprehensive Wellbeing and Mental Health program as an example to inform other programs seeking to serve their trainees

SUMMARY:

Medical students and residents experience burnout, depression, and substance abuse at high rates, which can adversely impact trainees' lives, can be associated with risk of suicide, and can compromise patient care. Moreover, psychiatric disorders which have been successfully treated prior to or during training often require ongoing care. The adverse consequences of physician burnout or the catastrophic results of inadequately treated mental health problems are all too common, and have attracted widespread attention in both professional publications and media reports. Medical schools and teaching hospitals have been slow to address these problems, though there has recently been a major push to upgrade availability of and access to wellness and psychiatric services. This importance of these efforts is illustrated in recent changes in graduate medical education requirements mandating wellness initiatives. This workshop will describe the expansion of the Mount Sinai Health System (MSHS) Student-Trainee Mental Health (STMH) service over the past several years which was fueled by several important events, including the suicide of a medical student and the development of the largest GME health system in the US. Administrators, clinicians and students together engaged in an intensive process, directed by the medical school dean, to identify the needs of trainees and to implement a comprehensive program to support their wellbeing and mental health. We undertook a rigorous review of current services, examined other university's programs to learn what was effective, convened several committees to drill down on various aspects of the existing program and desired future services. The resultant report called for an expansion of mental health services offered and the manner in which students were able to access them. Barriers to care such as stigma, cost, time constraints, fears about impact on future career, and concerns about confidentiality were addressed to improve accessibility and utilization. New screening strategies were identified and implemented to identify individuals at risk and facilitate entry into care. Priorities included support for wellness at the individual program level, the importance of screening for burnout and mental health problems, free or low cost services, and on-site and after hours

availability of treatment providers at each of the major teaching hospitals in the health system. In addition, new positions of Senior Associate Dean for Wellness and Resilience and Associate Deans for medical students, residents, graduate students and faculty were created. A cadre of “wellness champions” was identified and embedded within individual residency programs, and new initiatives were established to reduce clinical work intensity. Participants will also have the opportunity to discuss challenges in their own settings, and work on solutions in small discussion groups, with consultation from the workshop leaders.

Crossing the Psychiatric Quality Chasm From Different Angles: Perspectives for Administration, Education, and Clinical Practice

Chair: Luming Li, M.D.

Presenters: Tobias Diamond Wasser, M.D., Harold Alan Pincus, M.D., Susan M. Szulewski, M.D., Frank Ghinassi

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the nuances among measurement-based care and QI concepts as applicable to mental health professionals; 2) Identify national organizations actively involved in the development, monitoring, and reporting of psychiatric measures; 3) Recognize the current processes for researching, testing, and adopting new quality measures in psychiatry; 4) Review practical approaches to teaching QI to residents and interdisciplinary staff; and 5) Practice QI and MBC concepts in guided case discussion of a serious safety event and use a methodical approach for root cause analysis (RCA)

SUMMARY:

Since the Institute of Medicine report of "To Err is Human," many fields in medicine have found ways to introduce quality improvement (QI) concepts to bolster the delivery of safe patient care, and attempt to assure quality through measurement of clinical processes. QI describes an iterative process to improve clinical care, whereas measurement-based care (MBC) refers to assessment and monitoring of specific measures for process and outcome improvement within a specific practice context. As a

result, QI and MBC have emerged as important concepts for psychiatric administrators, policymakers, and hospital leaders. For practicing psychiatrists, developing additional skills in QI and MBC is both useful and essential, since these concepts are related to hospital accreditation and compensation, as well as physician credentialing and professional development. For clinician educators, the Accreditation Council for Graduate Medical Education (ACGME) requires all specialty training programs to educate trainees about QI tools such as the Plan-Do-Study-Act (PDSA) cycle and root-cause analyses (RCAs), and incorporate QI projects into curricula. All physicians practicing in a complex healthcare environment will need to understand QI and MBC, since several national organizations already task physicians to abide by measures in clinical practice, with frequent introduction and removal of these measures. In this session, the speakers will present administrative and policy perspectives on QI and MBC in psychiatry, and provide an overview of current and future trends in the field. The speakers also describe the research and development of new quality measures, the process for adoption of such measures, and discuss challenges to their implementation. New measures typically benefit from expert-level and organizational endorsement before being adopted and are then monitored by national organizations such as the Joint Commission (TJC) and hospital accreditation programs within the Centers of Medicare and Medicaid Services (CMS). In addition, one speaker will discuss efforts to implement patient-centered outcome measures within the emergency psychiatric practice setting. Furthermore, the session will include a brief discussion about QI education, and discuss experiences from a 4-year longitudinal curricular development project and a special type of QI case conference that apply RCAs and fishbone diagramming to strategize the improvement of interdisciplinary communication and care delivery. The session will conclude with an audience-driven case discussion of a serious safety event within a psychiatric practice setting, and emphasize the implications for QI and MBC in the domains of education, policy, research, and clinical practice.

Cultural Issues in Psychiatric Administration

Chair: Victor Buwalda, M.D., Ph.D.

Presenters: Altha J. Stewart, M.D., Dinesh Bhugra, M.D., H. Steven Moffic, M.D., Farooq Mohyuddin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) have knowledge of the personal journeys of multicultural leadership and the obstacles that must be overcome presented by two experienced multicultural psychiatric leaders; 2) have knowledge of the cultural problems that can arise in multicultural leadership; and 3) have knowledge of burnt-out and ethical issues in the field of multicultural leadership

SUMMARY:

Leadership in Psychiatry has been a topic of interest of psychiatrists for many decades. A well-trained psychiatrist needs different competencies to show effective leadership. Healthcare organizations perform much better when physicians are in leadership positions in the organization (McKinsey, 2008). While there is a need to get high potentials into leadership positions, good US training programs for psychiatric residency are rare or do not have a well-defined curriculum for Residency training (Mohyuddin et al, 2015). This session focuses on leadership issues, especially in relation to multicultural leadership, as multicultural leadership is needed in today's multicultural society. These leaders must be sensitive to tension problems between different cultures and turn these tensions into positive energy. Two extraordinary examples of experienced multicultural leadership will take the participants into the challenges they faced along the way to their current top jobs. Also the threat of burnout and its impact as ethical issues will be discussed. In the end, two of our eminent discussants will comment on what has been said during the session and give some advice for the future.

Debate: Covert Audio Recording of the Forensic Psychiatric Interview

Chair: Stephen G. Noffsinger, M.D.

Presenters: Ashley VanDercar, M.D., J.D., Sara G. West, M.D., Brian Scott Barnett, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the reasons that forensic examinees and attorneys may wish to covertly record the forensic interview.; 2) Understand the statutory and case law regarding open and covert recording of the psychiatric interview.; 3) Learn the potential benefits and risks associated with covert recording of the forensic interview.; and 4) Understand the legal ramifications and admissibility of a covertly recording forensic interview.

SUMMARY:

The psychiatric interview is an integral component of both the clinical and forensic mental health examination. Several factors may potentially contaminate (to a lesser or greater degree) the forensic mental health interview, flowing from either the examinee, attorney(s) and/or examiner. Examinees may attempt to malingering symptoms of a mental disorder and/or misattribute the cause of their genuine psychological symptoms to the litigated event. Attorneys may coach their client in an attempt to influence the subject's responses and demeanor in the examination to affect the outcome of the forensic interview. The examiner may conduct an inadequate forensic interview, engage in inaccurate evaluator observation, take poor notes, and/or fail to recognize and correct for their conscious and unconscious biases. Recognizing those potential contaminants, clinical patients, criminal defendants and civil litigants may covertly audiotape their psychiatric interview. Smartphones and iPads can become recording devices with the touch of a finger. Nearly two-thirds of Americans own a smartphone which can easily and covertly record a forensic interview. As methods to audio record conversations have become increasingly inexpensive, available, and portable, the likelihood and frequency of an evaluatee recording physician interactions (openly or covertly) has increased. Patients who secretly audio record the psychiatric interview may, in some cases, benefit from reviewing the audio recording at a later date. However, covert audio recording of the psychiatric interview may distort the results of the interview to the point of invalidating the interview, causing the clinical diagnosis and/or forensic opinion to be based on the unreliable data. Psychiatrists should be alert

to the possibility that an interview may be covertly recorded. This debate reviews the practice, benefits and dangers associated with covert recording, and how such recordings may be used in the courtroom. Recommendations are provided for the psychiatrist faced with the possibility that the interview has been secretly recorded.

Diagnostic Errors in Psychiatry (and Corrective Strategies): Clinical Cases (Ours and Yours!)

Chair: Barbara Schildkrout, M.D.

Presenter: Sepideh N. Bajestan, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define “diagnostic error” and indicate the magnitude of diagnostic error rates; 2) Recognize the complex factors involved in the diagnostic process and that these may be the focus of efforts to reduce diagnostic error; 3) Formulate how disease presentation as well as physician diagnostic thinking, both conscious and non-conscious, contribute to diagnostic delays and errors; 4) Explore the role of physician burn out in diagnostic errors; and 5) Specify at least five approaches that might help to reduce each clinician's own diagnostic error rate

SUMMARY:

Diagnostic errors are extremely common in all fields of medicine. Yet, the topic of how doctors make a diagnosis only became a major focus of attention after the Institute of Medicine issued a report -- Improving Diagnosis in Healthcare – published in September of 2016. Since then, investigators have developed a better understanding of the diagnostic process and also suggested approaches for improving diagnostic error rates. This session, co-sponsored by the American Neuropsychiatric Association, will introduce participants to the definition of diagnostic error, the magnitude of the problem, and to the complexity of the diagnostic process (including conscious and non-conscious elements). The role of cognitive biases in misdiagnosis will be emphasized, including misattribution error in which the patient is blamed for his/her disease; patients with behavioral symptoms and/or a psychiatric history are particular vulnerability to this bias as well as others. Next, we

will present numerous case examples of diagnostic delays or errors from our own psychiatric practice, neuropsychiatric practice, and supervision experiences. With each case we will explore the factors that led to the diagnostic delays or errors, and we will also describe approaches that might have lessened the possibility of error (cognitive time-out, consultation, cognitive forcing strategies such as exploring “what else” the diagnosis could be, and so on). The role of physician burnout in contributing to error rates will be discussed. Our session will emphasize that all physicians have missed a diagnosis or taken longer than would have been medically optimal to arrive at a correct diagnostic formulation. We will encourage discussion of cases, “ours and yours.” Our aim is to inspire attendees to contribute to improving diagnostic error rates in their own practices and in their own institutions. As the Institute of Medicine said, “[I]mproving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative.”

Diverse Career Pathways in Psychiatry: A Career Panel for Students and Residents

Chair: Tobias Diamond Wasser, M.D.

Presenters: Ayana Jordan, M.D., Ph.D., Brian Scott Fuehrlein, M.D., Ph.D., Pochu Ho, M.D., Misty Charissa Richards, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify multiple pathways to various career opportunities within psychiatry; 2) Weigh the benefits and challenges of different sub-specialty careers; and 3) Understand perspectives on different career pathways from early career psychiatrists in various sub-specialty fields

SUMMARY:

Medical students and psychiatry residents often have a rudimentary understanding that the field of psychiatry contains multiple subspecialties. However, during medical school and residency, students' and trainees' exposure to these various subspecialty fields is of a limited duration and specific to the setting where they train. Gaining a fuller understanding of the career opportunities that follow training/experience in ACGME-accredited

subspecialties (child/adolescent, geriatrics, forensics, addiction, consultation-liaison) and non-ACGME accredited opportunities (emergency psychiatry, public/administrative psychiatry, research, etc.) is imperative to provide learners with the full breadth of career prospects available within our growing field. Such an understanding may be particularly important for medical students in order to help continue the growth of our burgeoning field. In this presentation, a panel of presenters will highlight the variety of career opportunities within multiple psychiatric subspecialties in both academic and non-academic settings. Presenters, all early career psychiatrists practicing in diverse components of the mental health field, will describe their particular early career trajectory and pathways to their current position. These personal narratives will be used as illustrative examples to guide participants through the seemingly ominous path from trainee to practitioner in the field. Further, presenters will identify the multitude of career opportunities within their particular subspecialty that are available to further highlight for participants the variety of opportunities within psychiatry. Ample time will be allotted throughout for questions and interactive discussion with the audience.

Effects of Medicalization of Death Penalty on Physician Practice: Review of Current State Laws, Ethical Guidelines, and Death Penalty Litigations

Chair: Leon Ravin, M.D.

Presenters: Amanda Renee King, D.O., Iraj Rashid Siddiqi, M.D.

Discussants: Charles Dike, MB.Ch.B., M.P.H., Rebecca W. Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Examine the spectrum of medical decision-making in state-authorized executions throughout the evolution of death penalty laws in the U.S.; 2) 2. Recognize legal obligations of physicians to participate in state-authorized executions.; 3) 3. Discuss protections offered to physicians who participate or refuse to participate in executions in various states.; and 4) 4. Understand ethical and moral challenges psychiatrists face in current death penalty litigations.

SUMMARY:

In the course of medical practice, few decisions are more difficult than ones that could lead to the end of a human life. Additionally, the ethical principles of benevolence, nonmaleficence, and proscription against euthanasia outlined in the Hippocratic writing, have been guiding physicians' professional behavior for more than two millennia. A number of the Supreme Court decisions had direct impact on how the judicial system can utilize physician expertise in deciding criminal justice cases and imposing punishment including the death penalty. Those decisions opened doors for physicians' role in capital punishment cases that may be at odds with the founding ethical principles of medical practice. In recent decades, evolution of death penalty laws in the United States has led to the "medicalization" of death penalty. With intent to minimize the risk of suffering by the condemned, multiple jurisdictions seek physicians' advice regarding the means of execution or ask physicians to perform actions that would directly cause the death of the condemned. The American Medical Association and the American Psychiatric Association explicitly forbid physician participation in legally authorized executions. While the medical society remains divided in its attitude towards physician participation in state authorized executions, a number of states enacted laws mandating physician participation. Additionally, some states require psychiatrists' participation as a condition of execution of the condemned. More than two thirds of states with the death penalty have laws that explicitly address physician participation in execution. Of those states that require physician participation in execution, close to 90% require physicians to perform duties other than certifying death. Some states guarantee anonymity and/or license protection to physicians who participate in executions. Other states allow physicians to refuse participation based on moral or ethical grounds. Yet some states mandate physicians to participate in executions offering no anonymity or protections from licensing boards. During the course of the session the participants will review various state legislations directing physician participation in state-authorized executions as well as the ethical guidelines of physician professional organizations. The session will also offer the participants a first-hand experience of physician involvement in a death

penalty case. The panel discussion will allow participants to explore the legal, ethical, and moral decisions physicians must make when their involvement in legally authorized execution is sought out by the government.

Emerging Roles of C-L Psychiatrists: Addressing Interdisciplinary Care Transitions for the Medically Complex Patient

Chair: Liliya Gershengoren, M.D., M.P.H.

Presenters: Joseph J. Rasimas, M.D., Lorin Michael Scher, M.D., Felicia Wong, M.D.

Discussant: Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of the consultation-liaison psychiatrist as integral member of interdisciplinary team across inpatient and outpatient clinical settings; 2) Develop tools to facilitate professional development and encourage interdisciplinary learning; and 3) Recognize methods of communicating effectively with interdisciplinary team members regarding patient care and discharge planning

SUMMARY:

The ever-evolving and challenging role of the consultation-liaison psychiatrist continues to impact relationships with medical providers and influence patient care. This is especially pertinent when it comes to safe and effective patient discharge and follow-up planning. An essential task of any consulting psychiatrist is to consider patient disposition from the very first encounter. Clinical settings such as inpatient medical/surgical units, emergency departments, and outpatient medical clinics present their own unique challenges. The success of a psychiatric consultation and the ability to offer safe patient disposition planning subsequently depends on collaboration with interdisciplinary team members. The purpose of this workshop is to review scenarios where consult psychiatrists become the expert consultants with creative disposition planning for complex patients in a myriad of clinical settings. Dr. Liliya Gershengoren will describe her role as an embedded psychiatrist on an inpatient medical service. She will present the benefits and challenges of working within the

embedded psychiatrist model. Utilizing specific cases from the inpatient service, she will lead a discussion on the different effective ways of engaging in interdisciplinary education with the medical team to facilitate improvement in patient care and discharge planning. Dr. Lorin Scher will explore his role as a faculty psychiatrist at UC Davis integrating behavioral health and primary care across the Primary Care Network clinics. He will describe the implementation of depression screening, care coordination and care management services, e-consults, and tele-psychiatry. Furthermore, mechanisms of facilitating productive relationships with the ambulatory care clinical operations leadership team to address challenging patient cases will be presented for consideration. Dr. J.J. Rasimas will provide an overview of a consulting psychiatrist's role within a general emergency department. He will offer a discussion on meeting the needs of patient discharge planning in an efficient manner through targeted treatment offerings coupled to interdisciplinary collaborative efforts. Dr. Felicia Wong will discuss the challenges faced by consult psychiatrists within an integrated healthcare system when evaluating dementia patients presenting with behavioral disturbances. She will describe her leadership efforts locally in Orange County, and regionally with Kaiser Permanente Southern California, to promote a multidisciplinary approach to the management and safe discharge planning of this complex patient population. Dr. Philip R. Muskin is an expert in building and overseeing a consultation-liaison psychiatry service that routinely meets the needs of medical services and provides expert psychosomatic intervention. He is knowledgeable in consultative models and will be the moderator for this session.

Establishing a Required Mental Health Integration Rotation: Challenges and Opportunities in Training Our Next Generation of Psychiatrists

Chair: Rachel A. Weir, M.D.

Presenters: Roxanne L. Bartel, M.D., Brenner Freeman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of why there was a need for training psychiatry

residents in integrated/ consultative care models at the University of Utah; 2) Understand the potential difficulties of implementing a new required rotation in residency training, especially in a state with minimal funding for mental health programs; and 3) Understand the benefits of mental health integration and consultative opportunities at the trainee level, and the potential impact at the population level

SUMMARY:

The need to improve primary care consultation in psychiatry is increasingly being recognized as an important way to improve access and care for patients who struggle with mental illness, as well as improve primary care provider education on management of common mental health conditions. There are now a number of evidence-based care models across the country that have been implemented, such as collaborative care and telephonic psychiatry consultation. Many health care systems and academic centers recognize the need for such services, but funding is often a barrier, especially in systems that are not "at risk" for all patients, or in geographic areas where there is no state or public funding for such services. University of Utah Health is a tertiary care academic medical center consisting of four hospitals, approximately 25 owned ambulatory clinical sites, roughly 2,000 providers, and generates 1.7 million patient visits annually. It provides a portion of care for close to 13% of the state's 3 million population, and its full demographic reach covers nearly 10% of the Continental U.S. The University of Utah Community clinic system has been a leader in population health and team-based care, with care managers, care conferences with providers on high risk patients, and integrated social workers. However, psychiatry consultation was lacking and rated as a high source of need among providers. We will present details of an innovative model we developed at the University of Utah to improve psychiatry consultation and access to mental health treatment in primary care. Although other training programs have established opportunities for residents to practice mental health integration as elective rotations, our program is the first to our knowledge to establish a required rotation in MHI for all third year residents. The establishment of this rotation has greatly improved

primary care provider satisfaction with psychiatry at our institution and has reduced wait times. The additional benefits of the rotation have been improving psychiatry trainees' recognition of the high preponderance of mental illness in primary care, the improved ability to provide "curbside" consultation on patients we do not provide direct care for, and a better appreciation for the principles of population health that are driving many of the changes across the health care system as a whole.

Fact, Fiction, or Fraud: Clinical Documentation in Electronic Health Record Systems

Chair: Seth M. Powsner, M.D.

Presenters: Junji Takeshita, M.D., Carlyle Hung-Lun Chan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review challenges and pitfalls when documenting clinical encounters in common EHR (electronic health record) systems.; 2) Identify specific EHR constraints that participants find impede their regular work, if not already mentioned.; 3) Demonstrate practical adaptations to EHR constraints.; and 4) Demonstrate proper coding to bill appropriately based on a clinical encounter and its documentation.

SUMMARY:

In hospital based practices hand written notes have become an anachronism. Even in private practice, federal reimbursement policies and "meaningful use" requirements have pushed the remaining clinical world towards adopting Electronic Health Records (EHRs). This brave new world of electronic documentation is fraught with potential missteps. Our workshop will address some of the promises and pitfalls of EHR. Fact: Medical records are legal documents. They also serve as vehicles for communicating to other health professionals, and as a way for treating psychiatrists to review past events / decisions. We will discuss who should have access to psychiatric records. We will review in greater detail the various purposes of documentation including legal, HIPAA and special expectations for alcohol and substance abuse populations. We will also examine the role and content of psychotherapy notes. Fiction: Not all entries in daily EHR entries are

useful. We will examine uses and abuses of EHRs including: copy-and- paste, drop downs, scripts, intentional omissions, errors, templates, and use of speech recognition software. We will recommend tactics to avoid these traps. We will also explore ways to produce readable, understandable clinical entries. Comprehensible, not just legible notes, are possible. And it is possible to address the needs of a variety of readers, from nursing staff and covering clinicians to utilization review staff. Fraud: While fraud is rarely deliberate, it is no small task to provide proper documentation for a given level of service, to ensure proper billing. Both over-billing and under-billing are genuine causes for concern in any audit. Likewise, auditors may suspect fraud, rather than just keyboard fatigue, when clinical exam findings are copied forward day after day, one progress note to the next. We will review suggestions to substantiate the various levels of service. To reinforce the concepts presented, participants will be provided with cases of simple narratives of patient encounters. Their task will be to document on paper forms formatted to simulate the fixed options of EHR documentation and coding. Then they will share and review these with the presenters and their colleagues to correct misunderstandings and improve their documentation skills. Depending upon the number of participants, we may break into smaller groups.

Financing Integrated Care: *The* Major Obstacle to Widespread Implementation

Chair: Lori E. Raney, M.D.

Presenters: Lori E. Raney, M.D., Virna Little, Rebecca Kilmer Yowell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the services traditionally seen as non-billable in integrated settings; 2) List the specific CPT and other codes that can be used to capture much of the work of integrated care; 3) Describe the specific tasks and audit trail for the CPT codes for the collaborative care model; and 4) Appreciate the basic functionality of the Financial Modeling Workbook

SUMMARY:

The integration of primary care and behavioral health has received widespread support yet generally models with limited functions have been implemented primary due to lack of reimbursement for the core staff. With a the salary of a licensed social worker varying in the neighborhood of \$80,000 per year and a consulting psychiatric provider rate of \$150-250/hour, a primary care practice struggles to even begin to think of how they might get integrated care up and running in their organization. Couple this with building a registry, space allocation issues and EMR permissions and the cost can add up quickly. With the exception of organizations such as large integrated delivery systems with cash reserves (or cost savings) to support implementation, or groups such as the Veteran's Administration that have an all-in-one budget, the prospects seem grim outside of grant or other support for start-up. There are however sources of revenue that can be gleaned from various approaches with variable tasks to integrated care that can help cover a significant portion of the costs. Many of these revenue sources are available through Current Procedural Terminology (CPT), Health and Behavior Intervention (HABI) and other codes that are often overlooked. In addition, new CPT codes for the collaborative care model of integrated care are available for some populations and are currently underused. This presentation will bring together two experts in the field of integrated care (Lori Raney, MD and Virna Little, LCSW) to discuss the opportunities for funding that exist. Following a brief didactic session on the available codes and supplying the audience with an accompanying "cheat sheet", specific scenarios will be discussed in small groups to decide which codes could be billed and completing a "superbill" for each scenario. The small groups will also be introduced to the APA Financial Modeling Workbook to help them in their work with primary care clinics run scenarios for successful reimbursement.

Finding Opportunity in the Midst of Disruption: Lessons of Puerto Rico

Chairs: Sander Koyfman, M.D., Angel Brana

Presenters: Kathryn M. Salisbury, Ph.D., Charles Neighbors

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will learn how to best identify community needs and existing resources in the midst of major upheaval - such as after a natural disaster; 2) Attendees will discuss specific case history of Puerto Rico Integrated Care Symposium and methodology of creating measurable outcomes out of networking; 3) Attendees will understand principles behind basics of integrated care, disaster preparedness and systems learning to improve health care; 4) Attendees will have the opportunity to learn and discuss the issues of local ownership of outside relief resources; and 5) Attendees will learn of technology that makes community organizing a portable and translatable skill set akin to care coordination on population health levels

SUMMARY:

Aligning with the theme of APA Annual Meeting "Revitalize Psychiatry: Disrupt, Include, Engage, and Innovate" Disaster Psychiatry Outreach (DPO) in full partnership with Vibrant Emotional Health (former Mental Health Association of NYC (MHA-NYC) and Puerto Rico Academy of Medical Directors, Inc. (Academia de Directores Médicos de Puerto Rico) - organized and held a two day symposium titled "Disaster Preparedness and Response: Building Capacity - A Case for Care Integration" in San Juan, Puerto Rico in August 2018. The symposium was designed to offer an opportunity for local stakeholders to share their lived experience of responding and rebuilding systems following the devastation of recent natural disasters. Opportunities to strengthen the system of care through integration of behavioral health and primary care, regulatory change, best practices, value based payment and use of technology were explored by a distinguished group of invited speakers - including former Medicaid Directors, US Surgeon General and prominent local stakeholders - payers, providers, regulators and members of the public, including artists. We were able to focus on the following themes: * Disaster Preparedness and Response - lessons learned; capacity building, existing community needs and vulnerabilities - how to best capitalize on good will post disaster and move beyond the emergency. * Best Practices and Innovation - outcome driven care, restructuring ways

to pay for care in the times of limited resources. "Reusing the wheel" - best practices and innovation across the states. * Total Health approach – crisis response, medical, behavioral, substance use, pharmacy and wellness integration. Making a case for integrated care. * Provider Toolbox – concrete tools and approaches including Infrastructure and Arts as health care. * Art and culture and their role in recovery were shown and discussed. Target Audience was the Primary Care Providers, Mental Health Community providers, Policy Makers, First Responders and public at large – over 200 attendees, 56 presenters were in attendance. Tele and recorded access to the event were made available. By bringing practitioners, policymakers and insurers together this ambitious and wide ranging event was a first step toward measurable real-world integrative activity that is needed to improve system resilience. Participants and presenters continue to be engaged in the work to shape a unified vision of practice and policy change that will strengthen and disrupt the system of care in Puerto Rico with the goal of Rebuilding Better.

Forgotten No More: 2019 Intellectual and Developmental Disability Psychiatry Update

Chairs: Julie P. Gentile, M.D., Nita V. Bhatt, M.D., M.P.H.

Presenters: Allison E. Cowan, M.D., Destry East, D.O., Henrik Earl Close, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review clinical pearls on interviewing techniques, new pharmacologic updates, traumatic brain injury, and legal issues in intellectual disability (ID); 2) Using strawpolling and active audience participation, practice identifying and treating mental illness in the ID population; and 3) Identify common legal, behavioral, medical issues, and psychological issues encountered in ID psychiatry

SUMMARY:

The history of persons with mental illness and intellectual disability (ID) is profoundly intertwined. Both groups have been marginalized by society to varying degrees, and many practitioners are not confident in the provision of treatment for this

patient population. Society is moving away from the institutionalization of patients with ID and practitioners are more commonly treating patients with ID in the community setting. Due to limited experience and training treating ID patients, many clinicians feel inadequately prepared to address the complexities in this patient population. Common psychiatric illnesses as well as medical illness often can present differently; the Diagnostic Manual for Intellectual Disability is a resource that adapts criterion sets from the DSM-5 to better assess individuals with limited speech and behavioral presentations. Participants will be shown video clips of psychiatric illnesses and behavioral issues encountered in individuals with ID. Participants will discuss case scenarios pertaining to legal, behavioral, and medical comorbidities. The speakers in this workshop consist of a total of five members including two psychiatrists who treat ID patients on an outpatient basis and also serve as consultants to psychiatrists at state hospitals, a psychiatrist working with ID patients at a state hospital, and two psychiatric residents who treat ID patients on an outpatient basis. At the conclusion of this presentation, attendees will be provided with a quick reference manual that outlines clinical pearls including interviewing techniques, new pharmacologic updates, traumatic brain injury, and legal issues in ID.

Functional Neurological Disorders-We're Virtually There: A Discussion on Neuroscience, Delivering Diagnosis and Virtual Reality Treatment

Chair: Sepideh N. Bajestan, M.D., Ph.D.

Presenters: Kim D. Bullock, M.D., Luciana Giambarberi, M.D., Juliana Lockman, M.D., John Joseph Barry, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the neuroscience behind functional neurological symptoms disorder (FND); 2) demonstrate patient-centered communication with FND patients; and 3) recognize virtual reality treatment in FND

SUMMARY:

Functional Neurological Disorder, or FND (also known as Conversion Disorder), is complex and can

present amongst a variety of disciplines. While functional symptoms commonly occur, they are not clearly understood by the healthcare community. At times, FND patients go misdiagnosed for years, thus incurring high medical costs, potential side effects to treatment and disability. FND patients are also often stigmatized by clinicians who operate under the outdated assumption that these patients are malingering. Recent imaging studies have helped us to better understand the neurocircuitry linked to FND. Even so, there remains a lack of clinicians or scientists who can translate the neuroscience literature into accurate yet simplified concepts. An educational model consisting of patient-centered neuroscience teaching in the clinical setting may help bridge this gap. The present session will incorporate a brief overview of FND and focus mostly on educational training for physicians and trainees. Participants will role play a doctor-patient encounter delivering diagnosis and treatment recommendations for FND. Then, participants will review video of a similar encounter that delivers diagnosis based on neuroscience concepts. There will be time for discussion prior to transitioning to FND treatment with Virtual Reality. The latter part of this session will explore cutting edge research describing the use of Virtual Reality (VR) and Mirror Visual Feedback (MVF) for treating FND. There will also be a VR demonstration with volunteer participation. Further demonstrations may be available at the end of this session, should time remain.

Gender Bias in Academic Psychiatry in the Era of the #MeToo Movement

Chairs: Latoya Comer Frolov, M.D., M.P.H., Caitlin E. Hasser, M.D.

Presenters: Christina V. Mangurian, M.D., Maureen Sayres Van Niel, M.D., Kristen Berendzen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the concepts of stereotype threat, microaggressions, harassment and assault, all of which women psychiatrists may experience in the workplace; 2) Identify and understand the impact of systemic institutional gender bias in academic psychiatry; and 3) Identify tools and share strategies

proved effective to combat gender-based disparities and discrimination

SUMMARY:

The #MeToo Movement has brought national attention to the impact of sexual harassment and assault in numerous industries. As psychiatrists, we often treat women patients who are coping with the mental health impact of these incidents. However, women psychiatrists themselves are not immune to these experiences. Despite increasing numbers of women entering medical school, a recent meta-analysis showed that two thirds of medical trainees experience some form of harassment during training, and this problem continues in academic medicine (Fnaiss 2014). In a 2016 JAMA article, a third of women researchers in academic medicine surveyed said they had experienced sexual harassment with negative effects on their confidence and career advancement (Jagsi 2016). Not surprisingly, women remain underrepresented in leadership positions in medicine, including in academic psychiatry (Vaidya 2006). The glass ceiling for women in leadership positions in medicine may also have implications for the advancement of women's health more broadly (Carnes 2008). Women in academic medicine are impacted by stereotype threat impact on career advancement, and current childbearing and family leave policies may also have an impact on retention in academic medicine (Burgess 2012, Fassiotto 2016, Riano 2018). This workshop aims to explore the range of gender based experiences that women psychiatrists face. We will review the concepts of stereotype threat, microaggressions, harassment and assault, and their impact on individual performance. We will also give an overview of systemic institutional gender bias in academic medicine covering issues such as implicit bias in hiring, the presence or absence of a welcoming environment, pathways to promotion, compensation equity, grant support, and family care. Using an interactive format, we aim to clarify successful strategies to be implemented at both individual and institutional levels to reduce disparities and discrimination, such as resilience skill building, institutional climate change, stop-the-tenure track policies and effective supports.

Geriatric Forensic Psychiatry: Development and Content

Presenters: Jacob C. Holzer, M.D., Robert Kohn, M.D., Patricia Ryan Recupero, M.D., J.D., James Michael Ellison, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how this book was developed with the goals of providing a broad review of topics in geriatric forensic psychiatry to a number of professional audiences.; 2) Understand the goals of attorneys in working with geriatric forensic psychiatrists and be prepared to meet these needs.; 3) Describe the characteristics of dementia relative to a forensically informed understanding of its non-cognitive symptoms.; and 4) Understand the complexities of elder aggression and violence, including the influences of personality, intent, confusion and neurocognitive impairment.

SUMMARY:

Geriatric Forensic Psychiatry: Principles and Practice is one of the first textbooks to broadly approach the combined areas of geriatric and forensic psychiatry. The editors and authors of this book are honored to receive the Manfred S. Guttmacher award from the American Psychiatric Association (APA) and APA Foundation. The editors and authors represent a large cross-section of academic and clinical psychiatry, neuropsychiatry, psychology, neuropsychology, forensic behavioral professionals and geriatric professionals on a national and international level, are affiliated with numerous universities in the U.S. and abroad, and many are members of affiliated organizations, including the American Psychiatric Association, the American Association for Geriatric Psychiatry, and the American Academy of Psychiatry and the Law. This text represents the collaborative effort of these mental health professionals integrating the fields of geriatrics and forensic mental health, and several of the authors who supervised their chapter writing teams are senior members and leaders in the American Academy of Psychiatry and the Law. The goal of this textbook is to provide a comprehensive review of important topics in the intersection of geriatric psychiatry, medicine, clinical neuroscience, forensic psychiatry, and law. It is meant to address a

broad audience of professionals, including clinical and forensic psychiatry and mental health professionals, geriatricians and internists, attorneys and courts, regulators, and other professionals working with the older population. Topics addressed in this text, applied to the geriatric population, include clinical forensic evaluation, regulations and laws, civil commitment, different forms of capacity, guardianship, patient rights, medical-legal issues related to treatment, long term care and telemedicine, risk management, patient safety and error reduction, elder driving, sociopathy and aggression, offenders and the adjudication process, criminal evaluations, corrections, ethics, culture, cognitive impairment, substance abuse, trauma, older professionals, high risk behavior, and forensic mental health training and research. An innovative approach to this text, within the field of forensic psychiatry, was to attempt to broaden the application of more traditional forensic psychiatry topics, as applied to the older population, by including content related to risk management and neurocognition. The co-editors will present several brief topics central to the theme of this text, including the organization and development of the book, the value from the legal/attorney vantage point, the relationship of neurocognitive impairment and forensic issues such as civil commitment, and forensic issues involving aggression in the elderly.

I'm Facing 87 Years: Group Therapy in Juvenile Detention

Chairs: Joseph D. Hall, M.D., Marcia Unger, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the widespread need for mental health services in the juvenile detention setting and the role for group therapy in providing treatment.; 2) Summarize the literature regarding the efficacy of group therapy.; 3) Identify and subsequently compare and contrast different group therapy modalities.; and 4) Discuss the process and experience of developing and sustaining a therapy group within the Sacramento County Youth Detention Facility.

SUMMARY:

In the United States, two million young people are arrested per year and about 50,000 juveniles are incarcerated at any one time (OJJDP). Approximately 70% of arrested youth have a mental health condition, and juvenile rearrest rates are as high as 75% within three years of being released from confinement (NAMI). Therapy groups have been implemented as a mode of mental health treatment for incarcerated youths since the 1950s. Group therapy has the benefits of being inexpensive, efficient, and as effective as individual therapy. We will use straw polls throughout our presentation to engage the audience and assess their background with the topic. Over the last year, the speakers have conducted a long-term, weekly process group involving juveniles housed in the Sacramento County Youth Detention Facility. The therapy group includes a select group of adolescents within a leadership program who provide support and guidance to other detention residents who are struggling or causing significant disruptions on the units. Themes of discussion from the therapy group have included responsibilities to guide residents, relationships with each other and custody staff, and emotions surrounding their alleged crimes and incarcerations. We will discuss our experience, including our struggles and successes as well as feedback from our group members. Participants will be provided different real-life case scenarios from our experience conducting a therapy group that will be discussed in small groups. We will then facilitate a large-group discussion of these scenarios.

Implementing an Educational Trauma-Centered Specialty Clinic in an Academic Setting: From a SAFE Healing Project to an Engaging RESTART Program

Chair: Caroline Giroux, M.D.

Presenters: Andres F. Sciolla, M.D., Rebecca L. Short, D.O., M.P.H., Angel Hanson, Murat Pakyurek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to discuss the neuropsychological disruptions deriving from traumatic experiences using a trans-diagnostic framework.; 2) At the conclusion of this session, the participant will be able to list at least ten types of trauma that could lead to chronic mood

dysregulation, trauma- and stressor-related disorders.; 3) At the conclusion of this session, the participant will be able to identify resilience factors and promote a strength-based approach with patients.; 4) At the conclusion of this session, the participant will be able to provide the main components of a sanctuary model along with potential barriers and solutions for their implementation.; and 5) At the conclusion of this session, the participant will be able to develop a program to implement trauma-centered psychotherapy and trauma-informed pharmacotherapy.

SUMMARY:

Trauma is frequent and its levels of exposure are high in the USA (40-90%) [1]. Posttraumatic stress disorder (PTSD) has a lifetime prevalence of 7-12% but it is likely underestimated because many people with PTSD tend to not seek care. However, it is important to know that PTSD and other stressor-related syndromes are treatable conditions. Over the recent years, healthcare providers have been confronted with the reality of trauma and its lifelong, multifaceted impact on many survivors, because trauma affects the whole person (general health, mood regulation, self-esteem, belief systems, etc). As our society is also becoming more aware and vocal about abusive behavior (e.g., #metoo movement, public outcry from the separation of refugees from their families at the US-Mexico border, Black Lives Matter movement, etc), there is a pressing need for healthcare systems to provide comprehensive assessments and patient-centered care. Our presentation aims to discuss the foundational concepts of trauma-informed care and the specific process to develop culturally-sensitive, effective, empowering and sustainable trauma programs [2, 3]. To this end, our multidisciplinary panel will use as an example the development and preliminary results of the University of California, Davis, Resilience, Educational and Support Tools for Adults Recovering from Trauma (RESTART) Program. In addition, we will discuss its foundational project "SAFE" (mnemonic created while teaching on trauma-formed care), which stands for: Screen with Support, Attentive presence/Advocacy, Foster healing while Following the patient, and Explain, Empathize and Empower. We will promote active

learning through various techniques to engage the audience, demonstrate the application of key concepts and maximize the integration of knowledge. The session will include a video, quizzes, didactic presentations, a panel discussion, and a workshop segment facilitated by presenters, during which we will divide the audience into four groups, each receiving the following instruction: design your own program for a) underserved populations, b) children, c) women with peripartum symptoms and a prior history of trauma, and d) refugees and survivors of torture.

Implications and Challenges From Marijuana's Evolving Legal Status and Access for Adolescents and Emerging Adults

Chair: Theodore A. Petti, M.D.

Presenters: Christian J. Hopfer, M.D., David E. Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the vast differences at federal and state levels of variants in cannabis legalization; 2) Appreciate issues associated with the process of further cannabis legalization and their impact on adolescents and emerging adults, especially as related to rising levels of tetrahydrocannabinol; 3) Demonstrate recognition of options available to advocates and professionals to minimize the negative impact of further cannabis legalization on adolescents and emerging adults.; and 4) Discuss clinical and prevention challenges in light of claims of medicinal benefits and low risk perception of marijuana by adolescents and emerging adults

SUMMARY:

The movement to further legalize marijuana for adult recreational purposes has grown and garnered popular support throughout the United States and Canada. Little thought or planning has gone into consideration of the special needs and potential impact on adolescents and emerging adults in this process. This symposium summarizes the key issues and distinctions nationally between the gradients of legalized access to medical marijuana, decriminalization, and legalized recreational use for adults. Arguments for and against the legalization

gradient are summarized. Experiences in states with widely divergent histories of cannabis legalization are presented to illustrate how different levels of legalization and regulation have impacted adolescent access, use, adverse effects, and for those under age 21, legal risk. The evolution of marijuana legalization in California illustrates how the first state to legalize marijuana for medical purposes moved from fairly unrestricted use for adults with great diversion to adolescents onto more restricted access with legalization for recreational use by adults but more stringent regulations. The unintended consequences of cannabis dependence are demonstrated. A brief primer with criteria for successful diagnosis and assessment is provided and the role of psychiatrists and other primary care clinicians is emphasized. Colorado's experienced evolution from legalized medical marijuana to marijuana made legal for recreational use by adults allows consideration of the impact of the legalization process on youth perceptions of harm versus harmfulness and the subsequent increases in availability, social acceptance, introduction of new formulations, and lower prices. Diversion of marijuana to adolescents is considered as a critical consequence and concern for youth. Treatment and prevention challenges in the face of unfavorable conditions are addressed. New Jersey's experience typifies many states with legalized medical marijuana and associated issues of strict versus lax regulation and current state of affairs with push for unrestricted use by adults. Differences in the approaches implemented to prevent harm to youth provide insight for policy development. Participants are encouraged to share experiences and concerns of their states successful or unsuccessful approaches, issues and anticipated developments. Dangers posed to youth in the legalization process and cost/benefit considerations are opened for discussion especially those related to youth entanglement in the justice system. Participants will have greater understanding that the impact of legalization may be determined by the breath of marijuana's availability and extant regulations related to THC potency, and the extent to which adolescents and emerging adults are protected from diversion.

Integrating Addiction Treatment Into Primary Care: Opportunities for Psychiatrists

Chair: Dongchan Park, M.D.

Presenters: Brian Hurley, M.D., M.B.A., Jaesu Han, M.D., Hector Colon-Rivera, M.D., Adina Bowe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Evaluate evidence related to integrating substance use disorder services into primary care; 2) Identify the current individual and systematic barriers faced by primary care physicians who deliver substance use disorder treatment services; and 3) Describe future efforts to improve communication between psychiatrists and primary care physicians

SUMMARY:

There is a substantial body of evidence for providing screening, intervention, and referral for substance use disorder (SUD) in primary care clinics. They are efficacious, cost-effective, and expand access for treatment for substance use disorder. Smoking cessation, particularly, has been well embraced by primary care physicians, who have recognized the importance and effectiveness of treatment available in primary care clinics. For example, 90% of all smoking cessation services in the UK are provided in general practice setting. On the contrary, despite the recent efforts to increase access for treatment for alcohol and opioid use disorder, the collaborative care model for other SUDs remains underutilized. Primary care physicians, even after they get X-waivered training, tend to end up not prescribing buprenorphine for opioid use disorder. Similarly, utilization of pharmacotherapy for alcohol use disorder in primary care setting continues to be low. To explain the sub-optimal utilization rate for the collaborative care model, various barriers to integrating substance use disorder treatment into primary care have been identified in the literatures, both at the systematic and individual level. Lack of institutional support, informational deficits and negative attitudes were recognized barriers at the provider level, and were suggested to be targets for future interventions. It will be imperative to understand what primary care physicians everyday in their work settings before determining how to approach those barriers. This workshop will briefly

evaluate the existing evidence for collaborative care model for SUD treatment in primary care settings, and identify the barriers to integration of SUD treatment into primary care. Double-boarded psychiatrists in internal medicine/psychiatry and family medicine/psychiatry will lead workshop participants in an interactive simulation and role-playing of a typical primary care visit and facilitate a discussion on why providing treatment for AUD and OUD are more challenging than providing treatment for other conditions. Participants will then be asked to develop different strategies to address both the systematic and individual challenges in improving access for SUD treatment.

Lithium and Mood Stabilizing Anticonvulsants in Bipolar Disorder: Clinical Pearls and Biomarker Diamonds in the Rough

Chair: Mark Andrew Frye, M.D.

Presenters: Balwinder Singh, M.D., M.S., Susan Lynn McElroy, M.D., Terence Arthur Ketter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the definition and potential clinical impact of pharmacogenomics; 2) Better understand the FDA approval and evidence base of lithium and mood stabilizing anticonvulsants; and 3) Through case presentation and audience Q&A, review clinical pearls and potential biomarkers for lithium and mood stabilizing anticonvulsants

SUMMARY:

Over the past decade, pharmacogenetics has evolved scientifically from a focus on individual candidate genes to pharmaco-omics, merging genomic data with other “omics” information. Pharmacogenomics and other biomarkers of drug response are of increasing clinical interest and have potential to individualize treatment recommendations for bipolar patients, based on with greater precision for individual patients based on their biology. This does not replace a comprehensive clinical evaluation and synthesis of the evidence base for the patient seeking treatment for mood stabilization. This session will focus on FDA approved treatments well established in the bipolar pharmacopoeia including lithium (FDA approved 1970, 1974) and mood stabilizing anticonvulsants

divalproex sodium (1995), lamotrigine (2003), and carbamazepine (2004). Each drug will be reviewed for its FDA indication (s), evidence base synthesis in bipolar disorder, clinical pearls, and early biomarkers (i.e. diamonds in the rough”) that warrant further investigation. Clinical pearls will be reviewed by Dr. Balwinder Singh (lithium), Dr. Susan McElroy (divalproex sodium), Dr. Mark Frye (lamotrigine), and Dr. Terry Ketter (carbamazepine). Dr Robert Post will be our discussant.

Looking Past Nightmares and Flashbacks: Recognizing Complex Trauma-Related and Dissociative Disorders in the General Psychiatry Setting

Chair: Emily Elizabeth Haas, M.D.

Presenters: David Christopher Mancini, M.D., Benjamin Simon Preston Israel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify patients who should be screened for complex trauma-related and dissociative disorders, using case examples; 2) Understand how to ask about trauma in a way that is not “triggering” and is sensitive to the patient; 3) Demonstrate various techniques to screen for complex posttraumatic and dissociative symptoms. Review validated psychometric tools that can be used efficiently to supplement your clinical assessments; and 4) Gain understanding of what general psychiatric providers can do to help patients with complex trauma and dissociative disorders, including how to access specialized resources and coordinate care

SUMMARY:

It has been estimated that approximately 70 percent of adults in the United States have experienced a traumatic event at least once in their lifetime (7), and approximately 26% of children will experience or witness a traumatic event prior to the age of four (8). The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified the goal of establishing healthcare systems that provide trauma-informed care as one of its top six strategic public health initiatives. Most mental health professionals get training in recognizing and diagnosing posttraumatic stress disorder (PTSD) at a

very basic level. However, for some of our patients with trauma and complex psychiatric histories this may not be enough. What is the diagnosis when a patient presents with hallucinations, mood lability, inattentiveness, violent episodes with aggression, and self-harm? This patient may get diagnosed with schizophrenia, bipolar disorder, an impulse control disorder, borderline personality disorder, or a “treatment resistant” condition—but could these symptoms instead reflect trauma and pathological dissociation? As junior psychiatry residents, we were repeatedly faced with such questions during our time on the adult inpatient psychiatric services. In hindsight, the process of treating these complex cases may not have been as arduous if we had screened the patients more rigorously for PTSD and dissociative experiences. In this workshop, we will discuss clinical cases of patients presenting with complex psychiatric symptoms, who were at the time considered treatment refractory, and whose symptoms may have been more comprehensible and responsive to treatment had their traumatic and dissociative qualities been clarified. We will discuss how providers can more effectively recognize, screen for, and differentiate trauma-related and dissociative disorders from other conditions including mood disorders, psychotic disorders, and personality disorders. Lastly, we will discuss next steps that providers can take if there is concern for a complex trauma-related or dissociative disorder, and what strategies can help in treating this population.

Making the Invisible Visible: Using Art to Explore Bias and Hierarchy in Medicine

Chair: Nientara Anderson

Presenter: Robert Rock

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the role art can play in identifying and addressing bias that is inherent in society and affects provider patient interactions; 2) Describe identity hierarchies that exist in society and relate to patient-provider interaction, as well as among providers themselves; 3) Describe how the use of art allows a safe space for the discussion of identity and bias as they relate to clinical practice and intra-professional hierarchies; and 4) Be able to replicate and re-engage the specific process of using

art to explore bias (observation, interpretation, context-checking, and identifying relationships to medicine) described in the course

SUMMARY:

Making the Invisible Visible (MIV) is a guided art tour and reflection session for health professions students that has been incorporated into the curriculum of the Yale School of Medicine, the Yale Internal Medicine Residency Program, and the Yale Clinical Scholars Program (for attending physicians). The Institute of Medicine, the Liaison Committee on Medical Education, and the Accreditation Council for Graduate Medical Education have all designated training on cross-cultural interaction and elimination of bias as high-priority topics. There is a clear need for educational interventions that can educate medical trainees and attending physicians on the existence of biases, sensitize them to their own biases, and provide avenues for them to begin combating bias in themselves and the communities they are part of. In this workshop, we will demonstrate how art observation can be a means of entry into discussion and education on issues of bias in medicine. We will use reproductions of specially chosen paintings as a starting point to examine stereotypes embedded in our society as related to race, gender, class, sexual orientation, and other intersectional identities. Participants will be led through a four-step looking exercise. The first and second steps prompt them to provide purely observational descriptions and subjective interpretations of the painting with no historical context other than the visual information in the paintings. The method highlights the difference between observation and subjective interpretation as a means to explore the assumptions that inform our understanding, and how often we confuse our subjective interpretations for "objective" observations. This distinction is often especially important in psychiatry. The second and third steps provide participants with some historical context, then, through a series of guided questions, the historic meaning of each work and the artist's intentions will be interpreted through a contemporary lens and related to bias in modern medical practice. The biases that inform the various understandings of the painting will be related to the biases that influence patient-provider interactions,

clinical decision-making, peer-to-peer interactions and intra-institutional hierarchies. A guided reflection session will aid participants in processing their reactions as a group and sharing experiences from practice that relate to the topics of discussion. Session facilitators will use current research in existing healthcare disparities to contextualize the discussion and begin suggesting ways to combat the phenomenon in our practice and our society. The ultimate goal of the session is to develop comfort in describing the inherent assumptions and structural biases imbedded in western culture as well as their influence on clinical, personal, and professional interactions. In doing so, we will help participants to have much needed conversations around these increasingly pressing and relevant topics.

Medical Assistance in Dying: The Canadian Experience With Physician-Assisted Death

Chair: Elie Iseberg-Grzeda, M.D.

Presenter: Alan Bates, M.D., Ph.D.

Discussant: Sally Bean, J.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will be able to list 3 points (historical, ethical, or medico-legal) commonly encountered in the public conversation on Medical Assistance in Dying (MAID); 2) Attendees will be able to compare the requirements among different jurisdictions for psychiatric involvement during MAID; 3) Attendees will be able to list 3 roles for psychiatrists in the process of MAID.; and 4) Attendees will be able to identify two examples of gray area /nuance commonly encountered by psychiatrists during MAID eligibility assessments.

SUMMARY:

Background: In June 2016, Canada enacted legislation on physician assisted death, commonly referred to as Medical Assistance in Dying (MAID). Seemingly overnight, clinicians working with the medically ill have had to become comfortable discussing this topic when patients ask. Despite attempts to operationalize the process, grey areas remain. Many clinicians report not being comfortable with MAID, and controversy has played out on moral and religious grounds both among lay public and within healthcare spheres. Still, an

increasing number of jurisdictions are enacting legislation for physician assisted death, and learning about the Canadian MAID experience can help clinicians become more knowledgeable and competent in this area. Furthermore, it can improve psychiatric and psychosocial care in general because patient requests for hastened death routinely occur across all jurisdictions, regardless of the legality of MAID. Aim: This session aims to outline a brief history of the legalization of Medical Assistance in Dying (MAID) in Canada; describe the operationalization of MAID in Canada under current legislation; list various roles psychiatrists can play in the process; present preliminary statistics on where, when, and how MAID is occurring in Canada; and introduce challenging questions for the future. Methods: Data for this presentation have been collected from literature review, decisions from the Supreme Court of Canada, and reports from various provincial coroner's services in Canada. Data will be presented from actual cases of patients requesting MAID. Results: Since the first attempt to legalize MAID in the early 1990s, there has been a drastic shift in opinion, leading to the most recent Supreme Court of Canada decision in 2016. To be eligible for MAID, patients must be consenting adults; demonstrate decisional capacity; have a grievous and irremediable medical condition; and natural death has become reasonably foreseeable. MAID is mostly happening in hospitals but there are geographical differences across the country. Cancer is the most common illness prompting MAID. Psychiatric assessment is not mandatory, but psychiatrists may be well equipped to examine the grey area and nuance underlying eligibility assessments in many cases. Conclusions: The Canadian medical system is becoming accustomed to providing MAID. There remain gaps with the current legislation, and legal challenges regarding MAID for mental illness, MAID by Advance Directive, and MAID for mature minors seem to be on the horizon. Psychiatrists must be prepared since they are being called upon to help assess eligibility.

Mindfully Embracing Nutritional Wellness: Psychiatry 'Weighing In' on the Obesity Epidemic

Chairs: Robert Barris, M.D., Varun Mohan, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the link between mindfulness and physical wellness; 2) Embrace nutritional excellence in the context of a growing obesity epidemic; 3) Emphasize the role of a psychiatrist as not only a facilitator but as someone who embodies the practices of self-healing and wellbeing; 4) Draw similarities between food addiction and the substance addiction model of DSM-V; and 5) Incorporate an experiential component of mindfulness through a guided eating meditation exercise

SUMMARY:

The widespread epidemic of obesity in today's culture is ever growing with life expectancy actually now being reduced for the first time. It is therefore necessary for the physician to respond and tackle the issue head on. And psychiatry should be 'weighing in'. Obesity can be regarded as an eating disorder which can in fact be equated to a "substance use disorder" heading in DSM-V. Therefore, applying the addiction model to obesity is valid. Obesity reduces life expectancy more significantly than smoking and the healthcare system needs to be putting a clearer focus on this epidemic by mindfully embracing nutritional excellence. Physician obesity is an increasing problem with the United States being the biggest culprit. Of 19,000 physicians tested, 40% were recorded as overweight and 23% as obese. Now, more than ever, it is of utmost important for the physician to embody the practice rather than inform on it. Offering explicit information is necessary but is not sufficient. An implicit approach requires physician mindfulness, stepping out of the box to 'heal thyself', so as to not be overpowered by the shortcomings of the health care system and our very Western culture. More wealth and abundance has paradoxically led to diminished wellbeing- a 'suicide by fork' so to speak. Psychiatrists must 'weigh in' and mindfully embrace nutritional excellence both for themselves and in their patient care to curb the rampant obesity epidemic.

Navigating Racism: Addressing the Pervasive Role of Racial Bias in Mental Health

Chair: Karina Rae Espana

Presenters: David Roberto De Vela Nagarkatti-Gude, M.D., Ph.D., Paul L. Maitland-Mckinley, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize how racial bias can impede the delivery of equitable psychiatric services at multiple levels of care.; 2) Create a shared language when discussing bias, intersectionality, and racial discrimination.; 3) Examine the experience of racial discrimination as a patient, provider, and colleague, working to discuss ethical considerations and foster responsiveness to inequities.; and 4) Identify opportunities and an informed approach to label racial bias and mitigate racial disparities that are potentially powered by bias in a multi-disciplinary forum within mental health settings.

SUMMARY:

Historical frameworks have largely informed our perception of narratives for communities of color, rooted in prescribed roles that ultimately perpetuate bias. Bias is an essential element of the human condition; we are all vulnerable to biases, and we each carry a responsibility to navigate interactions in a way that encourages mutual respect. Honest inquiry into both the lived experience of an individual as well as previous interactions with systems of care, provides a platform to recognize complex historical pasts for communities of color, while working towards more equitable opportunities and outcomes. Collaborative treatment planning and thoughtful referrals to resources are but some of the specific interventions that can work to mitigate racial bias in mental health. Importantly, this conversation extends beyond a standing commitment to equity; it works to spark internal curiosity, motivation, and self-awareness that mobilizes one's own engagement in this conversation and bolsters inclusivity of each individual's narrative to promote healing. This session will begin by creating a shared language to establish a foundation for collaborative discussion about racial discrimination within the field of psychiatry. This will include reviewing the vocabulary and mechanisms around bias, the framework of intersectionality, and also colloquial terminology that is often used in our own communities to reference inequities. We will provide context for this discussion, including reviewing

evidence of racial inequities within the delivery of psychiatric services and how bias might play a role. We will consider case examples from mental health settings involving patients who experience and voice concern for racial discrimination by providers, providers who experience racial discrimination by patients, and providers who observe discriminatory behavior in a colleague. We will explore these cases in small groups and with the full audience, aiming to acknowledge the role of inclusive narratives as a powerful tool towards not only racial healing but also towards more nuanced interpretation of individual symptomatology. We will consider how mechanisms of implicit bias, ethical principles, structural influences, and interpersonal tensions interact to promote inequity, and will lay out informed approaches to work towards positive change on both the group and individual levels.

Physician Psychiatrists: Serving the Underserved Through the Medical Review of Systems and the Physical Exam

Chair: Eric G. Meyer, M.D.

Presenters: Lan-Anh T. Tran, D.O., Julia F. Jacobs, M.D., Shannon Christine Ford, M.D., Rohul Amin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Defend the use of a medical review of systems and the physical exam as part of the psychiatric intake; 2) Apply the differential diagnosis of specific symptoms to determine which medical review of systems questions and physical exam maneuvers are indicated; 3) Demonstrate components of the basic physical exam; 4) Recall medical review of systems questions as organized by psychiatric symptom; and 5) Describe methods to acknowledge and process transference issues associated with the physical exam in a psychiatric intake

SUMMARY:

Every DSM-5 diagnosis includes an exclusion criterion that the disorder is not better explained by a medical condition. Meeting this criterion can be difficult for a variety of reasons. The psychiatric signs and symptoms of medical disorders are not commonly emphasized in medical textbooks.

Further, illness scripts for medical diagnoses do not often overlap with psychiatric disorders, making it difficult to know what medical conditions should be ruled out. For example, irritability is a common symptom in polycystic ovarian disorder, but PCOS is rarely on the differential for irritability. Similarly, while hypothyroidism is commonly linked to the illness script of depression, patients with MDD may be just as likely to have diabetes - an infrequently considered diagnosis for depression. "Buzzword" medical conditions that are commonly prioritized in medical student training can negatively influence classic illness scripts. While such diagnostic possibilities make for good multiple-choice questions, they are frequently rare and may inadvertently undermine important common possibilities. For example, a patient with chest pain in the context of anxiety is more likely to have asthma, acute coronary syndrome, or even a pulmonary embolism than pheochromocytoma. In a recent white paper issued by the American Psychiatric Association, it has urged psychiatrists to better advocate for patients with severe mental illness who often lack access to primary care. But some psychiatrists may be unfamiliar with physical exam maneuvers and medical review of systems (ROS) questions. Complex medical systems may delegate the physical exam to physicians outside of psychiatry, or there may be a temptation to rely on the emergency room's "medical clearance" as a "medical rule-out." Both can result in decreased familiarity with physical exam techniques previously mastered as part of medical school. A cursory review of the physical exam maneuvers and concise symptom-based medical ROS lists can alleviate some of these concerns. It is also important to consider the potential transference issues that may arise in completing physical exam maneuvers in psychiatric patients. It was previously theorized that the potential for sexualizing an encounter through the physical exam was sufficient cause to avoid a physical exam altogether. Avoiding the physical exam may instead instill a sense of distrust in patients. Indeed, transference is possible in any medical setting, and it is especially important to be prepared for it in a psychiatric setting.

Psychoeducation of Borderline Personality Disorder: Implementation and Benefits

Chair: Mary C. Zanarini, Ed.D.

Presenters: Sara R. Masland, Ph.D., Maria Elena Ridolfi, M.D., Mary C. Zanarini, Ed.D., Ellen F. Finch, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Document the significant and enduring benefits that psychoeducation (PE) about BPD can have for patients, professionals, and psychiatric residents; 2) Describe methods of providing PE of BPD via professional workshops, 12 session therapy, web-based videotapes, and teaching seminars; and 3) Develop optimistic attitudes about the use of PE as a treatment intervention with lasting benefits

SUMMARY:

These presentations will inform clinicians about the clinically significant effects of PE about BPD. This thesis boldly challenges the reluctance of many clinicians to disclose the BPD diagnosis for fear this will dismay or alienate. Presentations are from four recent independently conducted studies that used widely different methods and designs. The modes of implementing PE and the content of what it includes vary considerably. Masland et al. document improved and enduring optimism and sense of competence of mental health professionals after attending a one-day workshop on BPD. Ridolfi reports an RCT in which 12 sessions of professionally-led psychoeducation led to significantly greater improvements in all sectors of BPD psychotherapy and that these changes were sustained over an eight-week follow-up. Zanarini's web-based psychoeducation program allows for wide and inexpensive utilization. She describes its content and its impressive benefits for BPD patients. Finch's study describes a 100-item instrument that assesses skills in managing BPD patients. She illustrates how it can document clinician competence and be used to evaluate learning during residency training – where its results demonstrate where education succeeds and fails. Hoffman describes her psychoeducation program for parents with children with BPD. Altogether, these five presentations are expected to improve the comfort with which clinicians, trainees, and parents use

psychoeducation to improve the lives of patients with BPD.

Psychopharmacology and Sleep: A Review of Psychiatric Medications and Their Effects on Sleep Physiology

Chair: Nikhil Pillarisetti Rao, M.D.

Presenters: Kim Christopher Knudson, D.O., Suraj Modi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an overview sleep physiology including neurocircuitry and sleep architecture; 2) Review common sleep pathologies including disorders of movement, sequencing, breathing, and arousal; 3) Explore secondary effects on sleep (both beneficial and detrimental) of common psychotropic medications used for mood, anxiety, and psychosis; 4) Elucidate negative consequences associated with common medications used for sleep; and 5) Discuss case examples of how sleep physiology and pathology impacts choice of primary psychiatric medication

SUMMARY:

Sleep disorders are increasingly common in the general population and constitute a major source of medical and psychiatric morbidity. Individuals with psychiatric illness may be at increased risk for a wide range of sleep disorders involving anything from breathing to movement. Psychiatric medications, due to their effects on brain regions such as the hypothalamus and reticular activating system have wide-ranging effects on sleep, often incidental to their prescribed purpose. These may be positive, as in topiramate's suppression of central sleep apnea, or negative, as in the antidepressants' association with sleep movement disorders. Confoundingly, some are used for sleep induction and maintenance despite negative consequences to sleep architecture and cognitive/emotional functioning. This session seeks to review the role of psychiatric medications in exacerbating and alleviating common sleep disorders including obstructive sleep apnea, central sleep apnea, REM sleep disorders, parasomnias, PLMD/RLS/Bruxism and arousal. We will also discuss psychiatric medications' effects on sleep architecture with specific attention to REM sleep

density, cycle length, and deep stage sleep as well as potential long-term consequences to cognitive, emotional, and physical health. We will begin with a brief overview of sleep neurophysiology and architecture before discussing common sleep pathologies and their consequences for neuropsychiatric functioning. Next we will discuss common classes of psychotropic medications including antidepressants and antipsychotics and their often underappreciated secondary effects on sleep. A summary handout will be provided to the audience for reference. After then discussing commonly used sleep agents--often chosen for induction or maintenance rather than quality--and the potential pitfalls therein, we will explore a series of hypothetical clinical scenarios in which psychotropics play a role in either alleviating or exacerbating sleep difficulties.

Recipe for Disaster: Helping Communities Heal Through Man-Made and Natural Disasters

Chair: Ana T. Turner, M.D.

Presenters: Daniel Lewis, Steven Paul Cuffe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the breadth of damage Hurricane Irma caused within Duval County; 2) Describe methods for sustaining a major academic center before, during, and after a major hurricane hits; 3) Investigate methods that have helped or not helped after a mass shooting; and 4) Construct a framework for preparing for natural and man-made disasters in any community

SUMMARY:

In one year the community of Jacksonville, FL, has experienced both a major natural disaster and man-made disaster. Hurricane Irma moved across north-central Florida early Sept 11, 2017, and was estimated to be the fifth-costliest hurricane ever to affect the United States, with wind and water damage totaling approximately \$50 billion. In the United States, 10 direct deaths were reported, two of which occurred in Duval County, where a 59-year-old male and a 54-year-old female drowned due to fresh water flooding when their tent was submerged in water in the woods. Then, on August 26, 2018, an armed shooter killed two people and wounded

several others before the gunman killed himself. With such exposure to disaster, we propose a 90minute general session highlighting our experience managing disasters within an academic psychiatry department, and help establish framework for next steps that communities can take when disaster strikes. The heavy rains from Hurricane Irma caused rivers to reach major or record flood stages, leading to significant flooding in the Jacksonville area. Flood waters rushed into the city's streets and reached up to 5 ft deep in some locations, overall one of the worst flooding events in the city's 225+ year history. We will describe how our academic medical center prepared for patients and staff to be sequestered with decreased access to power and water, as well as highlighting the ethical management of patients with no secure shelter and also no access to acute medical care. We will then describe effective and ineffective strategies for dealing with the aftermath of such a disaster. We will then describe how a community fresh from healing experienced its second disaster in one year. With Duval County experiencing 5,082 reported crimes involving firearms in 2017, one involving the shooting of two people at a high school football game only two days prior to the mass shooting, violence is not something new to our county. We will discuss how emergency medical services prepared for and responded to the mass-shooting tragedy as well as our department's response to the tragedy in the weeks and months thereafter with specific case examples. Lastly, we will explain key concepts of Disaster Psychiatry and hold an interactive discussion allowing the audience to construct their own framework for preparing for natural and man-made disasters in their own communities.

Revitalizing Psychiatry Through Engaging With Innovation to Increase Access and Inclusion With Care

Chair: John Torous, M.D.

Presenters: Abhishek Pratap, Mark Larsen, Ph.D., Bridianne O'Dea, Ph.D., Julien Epps, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify three ways that technology can increase access to mental health care; 2) Recognize how technology design can

reduce health disparities through increasing uptake and adherence to mental health technology; 3) Understand global mental health efforts around technology use to bring care to underserved population; 4) Discuss best practices for introducing technology tools into health disparity settings; and 5) Assess the potential and readiness of your practice for using technology to reduce health disparities

SUMMARY:

Revitalizing psychiatry means maintaining the fields' high standards but being open to new innovations that engage both clinicians and patients towards better mental health. In this three hour session, we will utilize novel hands on teaching methods to introduce psychiatrists to five clinically relevant innovations and offer interactive demonstrations on picking safe smartphone apps for patients to engage with, using social media to predict and respond to thoughts of suicide, smartphone sensors to predict relapse in serious mental illnesses, voice analysis to predict changes in mood, and mobile technology to promote increased physical activity among patients with serious mental illnesses. In presenting each of these four innovations, we will focus on how these technologies can make psychiatry more inclusive, accessible, and engaging. We will demonstrate how rather than disrupt, busy practicing psychiatrists can apply the lessons from this session to augment their clinical care today.

Revitalizing Psychiatry—and Our World—With a Social Lens

Chair: Sheila Judge, M.D.

Presenters: Kenneth Stewart Thompson, M.D., John H. Halpern, M.D., Eugenio M. Rothe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to be familiar with the history, terms, and processes of xenophobia, acculturation, and inter-culturation in treating those affected by migration; 2) The participant will be able to examine in depth broader issues of law, trauma, personal safety and violence, in controversies over gun control and mental illness; 3) The participant will be able to recognize the importance and potential effects of environmental

factors (e.g. overcrowding, air quality, climate) on the development of psychiatric morbidity; 4) The participant will be able to understand some of the values of ethical leadership in choices that can create conditions of social and psychological well-being; and 5) The participant will be able to utilize awareness of the extensive influence of social factors during each clinical evaluation and encounter

SUMMARY:

Social factors contribute to the maintenance of psychological well-being, and social factors are core to all behavioral health issues. This perspective influences our current understanding of neurodevelopment and brain plasticity, the interplay of environmental factors with vulnerability in the onset of mental illness, and social determinants of mental health and recovery—to name but a few relevant areas. Appreciating the broad range of influences that accompany one's life journey and which challenge resilience and health is critical to clinical competence in psychiatry, as is understanding the interplay of intrapsychic and interpersonal responses in the social fields of family, community, and nation. The 2019 Humanitarian Forum will be what the name implies: a lively exchange of ideas and experiences about the choices a society makes that can profoundly influence an individual's well-being—or threaten mental health. In recognition of Governor Jerry Brown, the 8th recipient of the Abraham L. Halpern Humanitarian Award of the American Association for Social Psychiatry, we have chosen four areas from the many challenges and opportunities to improve the social and cultural surround that arose during his terms as Governor of California, to serve as springboards to delineate, discuss, and debate: environment, violence/gun control, immigration, and values in leadership. American daily life has changed dramatically: not since the era of wagon trains has the prospect of sudden random personal and mass violence been not only real but possible anywhere. Safety and fears for the future also play out in controversies about environment, from neighborhoods to natural resources. The spotlight on the humane treatment of refugees is the latest chapter in the cycle of prejudice and stigma, often used for political purpose but very real to those vulnerable and traumatized. In considering all such

areas of societal engagement, intrapsychic tendencies become manifest in economic, political, and interpersonal discourse; decisions made in these arenas then reverberate and profoundly affect individual and community life and responses. A practicing psychiatrist cannot ignore social conditions without risking incomplete assessment, interventions without compassion, and/or failure in treatment planning.

Social Media and Psychiatry: Challenges and Opportunities

Chair: Carol Ann Bernstein, M.D.

Presenters: Diya Banerjee, M.D., Nadejda Bepalova, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the different forms of social media and their general use; 2) Identify ways that social media intersects with clinical practice through specific examples; 3) Understand how these platforms can be both helpful and harmful to the therapeutic relationship; and 4) Develop a framework for thoughtful participation in social media

SUMMARY:

Social media—Facebook, Twitter, Snapchat, Instagram—has become an increasing part of everyday life. Every field has had to reckon with it, including law enforcement, politics, journalism, academia and increasingly, medicine. Social media has several facets, serving as a source of information, a means of communication and an intersection between the public and private spheres of life. If psychiatrists are more aware of these platforms, they will be able to develop a proactive and thoughtful approach to engagement with social media in order to connect with patients and the public in novel ways. The seminar aims to take a broad look at how psychiatry and social media are intertwined through both an academic and experiential lens. We will review the existing literature that comments on the interface between social media and clinical practice, highlighting opportunities (such as educational outreach and critical information gathering during emergencies) as well as pitfalls (such as privacy concerns and

problematic boundaries). We will also demonstrate real world examples of individual cases where social media influences outcomes. Furthermore, we will examine the societal implications of increasingly prevalent social media use on psychiatry. The workshop will be structured to invite discussion from panelists and audience members about their own experiences and perspectives.

Stepped Care as a Model for the Treatment of Borderline Personality Disorder

Chair: Joel Paris, M.D.

Presenters: Lois W. Choi-Kain, M.D., Richard E. Hibbard, M.D., Ronald Fraser, M.D., Andrew Chanen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand the evidence for the use of stepped care in the treatment of BPD.; 2) At the conclusion of this session, the participant will be able to understand how this approach conforms with the evidence base in the literature.; 3) At the conclusion of this session, the participant will be able to understand how stepped care applies to comorbidities and to specific age groups.; and 4) At the conclusion of this session, the participant will be able to understand how stepped care can make treatment for BPD accessible.

SUMMARY:

This symposium will present a new model for the treatment of Borderline Personality Disorder, designed to make it more accessible and to fit into the needs of both acute and chronic presentations. While several manualized psychotherapies for the treatment of BPD have been validated in RCTs, brief and less specialized forms of treatment are needed for implementation to meet public health needs. Dr. Choi-Kain will evaluate the evidence for briefer and less specialized treatments for BPD, while acknowledging the utility of more intensive treatment for specific clinical profiles. Brief formats of evidence based treatments, particularly a 10 session assessment/consultation and 8 session group protocol of general psychiatric management will be presented. Advances in neuroscience support

the hypothesis that information flow in brain pathways is the basis for emotional function. Animal models suggest bifurcation of a pathway through the amygdala that results in either passive fear or active coping behaviour. Dr. Hibbard will postulate that modulatory inputs to the amygdala can be shaped in ways that create a bias toward active coping. He will then describe a stepped care delivery model for addictions and BPD that incorporates strategies that enhance the active coping pathway. There are evidence-based psychotherapies for BPD patients, but they are resource-intensive, expensive, lengthy, and generally unavailable. Dr. Paris will describe an approach based on a stepped care model that has been used in other medical specialties, as well as psychiatry. By providing short-term care to most patients, and by reserving long-term care for those who are more seriously disabled, resources are retained to treat more patients, leading to a near-abolition of waiting lists. Dr. Paris will present data showing that brief therapy, lasting for 12 weeks, is effective for many if not most cases of BPD. Dr. Fraser will present effectiveness data on a more extended program designed for more chronic and severe cases, which is meant to be complementary to the existing short-term program for BPD. This presentation will outline the basic structure, team composition, philosophy and treatment modalities, and examine patient characteristics and treatment outcomes. Dr. Chanen will describe how the diagnosis of BPD is typically delayed, empirically supported treatments are largely inaccessible, and iatrogenic harm is still a common outcome. Evidence will be presented suggesting that individual psychotherapy is neither necessary nor sufficient for the treatment of all individuals with BPD and that it has little effect upon long-term psychosocial functioning. "Clinical staging," similar to disease staging in general medicine, will be presented as a pragmatic, heuristic framework to guide prevention of and intervention for BPD. The audience will be invited to debate these issues in Q&A format following each presentation, with an extended Q&A session at the end.

The Aggrieved Patient: Challenges District Branches Face in Handling Complaints

Chairs: Brian Crowley, M.D., Corina Freitas, M.D., M.B.A., M.Sc.

Presenters: Catherine Stuart May, M.D., Philip Candilis, M.D., Moira Wertheimer, Esq., R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand patient motivations leading to complaints; 2) Discuss how a complaint can lead to board complaints and lawsuits; 3) Identify strategies to minimize risk of legal challenges; 4) Demonstrate the range of patient complaints, their level of severity, motivations involved, and options for fair and beneficial handling; and 5) Review the modus operandi of Ethics Committees in the APA

SUMMARY:

Patients with grievances who seek advice, redress, and closure, turn to the APA through its District Branch (DB) Ethics Committees. Alongside traditional ethical complaints about boundaries, conflict of interest, and mistreatment, some are matters of etiquette, miscommunication, or misunderstanding. Currently all public complaints are filed with a DBs Ethics Committee, where their eligibility is judged by the APA's code of ethics. If supported by APA definitions, a investigation is conducted by an investigatory panel. If a violation is confirmed, the investigation is summarized and the APAs Ethics Committee is informed. If a complaint does not rise to the level of a violation, it is simply dismissed, and because of privacy, respondent physicians cannot be advised in any way. In the past, the Washington Psychiatric Society (WPS) found a Grievance Committee useful in managing complaints that did not reach violation status. In this session, speakers with extensive DB and APA experience will identify common motivations for complaints, , offer a typology of complaints and complainants, review case examples, and summarize useful operational strategies. Improvements to the process will be offered through a discussion of risk mitigation during the complaint process, including prompt access to legal representation, sensitivity to the potential for referral to the APA, and the possibility of legal challenges. A significant portion of the session will be committed to audience discussion. Overall, will explore the universe of complaints and discusses useful processes for handling and achieving beneficial outcomes.

**The American Journal of Psychiatry
Residents' Journal: A Resident-Led, Peer-Reviewed
Journal Supporting Psychiatric Trainee Scholarship**

Chairs: Oliver Glass, M.D., Shapir Rosenberg, M.D.

*Presenters: Alexander G. Cole, M.D., Erik Bayona,
M.D., Somya Abubucker, M.D., Jason Lee Garner,
M.D., Carol Ka-Lap Chan, M.B.B.S., Lindsay Lebin,
M.D., Matthew Louis Edwards, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Publicize the Residents' Journal; 2) Demonstrate benefits of trainee publication efforts; 3) Identify common issues in manuscript authoring and publication processes; 4) Demonstrate new initiatives of the 2018-2019 editorial board; and 5) Show the process involved in submitting, revising, and publishing a manuscript

SUMMARY:

The American Journal of Psychiatry Residents' Journal is a promising vehicle for trainees to author, edit and review manuscripts early in their careers. Academic writing is a challenging and fulfilling form of expression that improves with practice. Publishing in peer-reviewed journals opens opportunities to psychiatrists as they begin establishing their careers; however, most residents finish their training without a peer-reviewed publication. The reasons for this are manifold. We suspect that they include a sense that with all the demands of residency training, writing and publishing an article can seem daunting. Furthermore, once an article is written, many trainees struggle to get their work published. This discrepancy between career desire and perceived opportunity might underlie some of the physician burnout that is epidemic in modern medical cultures. The Residents' Journal hopes to bridge the gap between aspiration and opportunity by providing psychiatrists at all stages of training with a channel for self-expression. This workshop is designed to acquaint medical students, residents, and fellows with the Residents' Journal, such that they emerge confident that they can author a manuscript in the coming academic year. Trainees will become familiar with common errors encountered during the editing process, which may

preclude or delay publication. By the end of the workshop, participants will be able to identify and avoid these setbacks. They will understand the many possibilities that the Residents' Journal affords for leadership and ongoing collaboration. We hope that our participants will be able to describe the mission of the Journal and be able to share criteria for involvement with their colleagues and peers. Psychiatrists in all stages of training will engage with one another to help identify ways for trainees to participate in the writing, editing, and peer review of the Residents' Journal. The workshop will impart valuable skills and connections that will be useful to trainees as they start to build their careers within psychiatry.

**The Fundamentals of Mentalizing-Based Therapy
for Personality Disorders**

Chairs: Carl Fleisher, M.D., Robin Kissell, M.D.

*Presenters: John Charles Kelleher, M.D., Jolene
Katherine Sawyer, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relations between mentalizing, attachment and learning; 2) Distinguish mentalizing from non-mentalizing; 3) Deliver interventions such as clarification and challenge to restore mentalizing; and 4) Employ empathy and an inquiring stance in the midst of emotional arousal

SUMMARY:

This session offers an introduction to what mentalizing is and how it is used (Bateman and Fonagy, 2016). We will discuss the context in which people develop the capacity to mentalize and its vulnerabilities, which are a core impairment in personality disorders (Fonagy et al., 2017). Mentalizing is the aspect of social cognition that enables human beings to interpret their own and others' behavior in terms of mental states such as needs, desires, thoughts, feelings, and beliefs, and as such is fundamental to our interpersonal relationships and to the therapy process. Participants will learn about the assessment of mentalizing, about the dimensions of mentalizing and about the therapeutic techniques required to restore mentalizing. Workshop leaders will

demonstrate mentalizing skills, for example in assessing strengths and vulnerabilities in patients with personality disorders as well as in those who self-harm. Participants will view videotaped clinical material, then break into small groups to practice a mentalizing approach to therapy.

The Melancholy of the Lincolns: What We Can Learn About the History of Psychiatry Through the Cases of the President and His Wife

Chair: David Allan Casey, M.D.

Presenter: Brian Andrew Casey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The attendee will understand the psychiatric histories of both Abraham and Mary Todd Lincoln; 2) The participant will understand the controversies over their proposed psychiatric and medical histories; 3) The participant will understand how their cases shed light on questions such as the objectivity and validity of psychiatric diagnoses, culture bound syndromes, involuntary hospitalization and the Gold; and 4) The participant will understand how the cases have been used to advance points of view about social causes such as feminism and LGBTQ acceptance.

SUMMARY:

Both Abraham Lincoln and his wife, Mary Todd Lincoln, suffered from depressive symptoms. By many accounts, Ms. Lincoln also suffered from mood swings, delusions, behavioral disturbances, and suicidal thinking or actions. Both received treatments common to the times. Mary Todd Lincoln was involuntarily hospitalized primarily at the behest of her son, Robert Lincoln, acting in part on the advice of physicians. Her situation was widely reported in the press, provoking strong public reaction. She was an unpopular public figure during and after her husband's service and assassination, but public sentiment turned in her favor during her commitment. Public pressure probably contributed to her early discharge. Neither Lincoln wrote a memoir. Many articles and books have explored the possible diagnoses, explanations, and meanings of these cases. Many have explored possible medical illnesses which could explain psychiatric symptoms, such as a widely discussed (and likely erroneous)

putative diagnosis of Marfan's for President Lincoln. Mary Todd Lincoln has been retrospectively diagnosed with bipolar disorder by a number of authors. However, skeptics also abound. Even contemporaneously, during and after her commitment proceedings, questions were raised about the fairness of the process and accuracy of the testimony. Some modern authors have discussed her case from a feminist perspective, viewing her as an outspoken woman who was unfairly labeled and confined by controlling men. Lacking any firsthand accounts, the ambiguities of the cases open the door to many interpretations, including support of a particular cause or point of view. For historians of psychiatry these are rich sources of discussion of disparate concerns. Is it possible (or ethical) to diagnose from afar with incomplete information? Were the facts originally recorded accurately, or filtered? Do we reify, simply looking to check off modern criteria, assigning more meaning to some signals than others? Is it appropriate to rely on modern criteria for diagnosis? And, what if those criteria change in the future? Will a retrospective diagnosis then change? Can diagnosis be taken to be valid and objective? Does the nature of psychiatric illness evolve over time? How about the issues inherent in involuntary hospitalization? Have they changed in 150 years?

The South African Society of Psychiatrists (SASOP) and American Psychiatric Association (APA): Relations and Roles

Chairs: Albert Bernard Janse van Rensburg, Ph.D., M.Med., Saul Levin, M.D., M.P.A.

Presenters: Bonginkosi Chiliza, M.B.B.S., Soraya Seedat, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate the relations between and roles of the SASOP and APA over time; 2) Understand the developing relations between South African and American Psychiatry; and 3) Provide an update of current training of psychiatrists in context of English speaking colleges of Psychiatry

SUMMARY:

During the Apartheid years, the United Nations' "Special Committee against Apartheid" (UN SCAA)

was the driving force behind UN action to isolate the apartheid regime in South Africa and support the movement for a non-racial democratic society. While ongoing debate was conducted at the time and mounting criticism also appeared in the medical literature including in the Lancet and the American Journal of Psychiatry [1], the investigation of the then South African mental health care services culminated in the APA appointed Committee's report on its visit to South Africa in September 1978 [2]. The visiting APA Committee took the different charges made by the World Health Organization (WHO) under review and addressed several of its recommendations to the "Association of South African Psychiatrists." The latter, which existed then as the "Society of Psychiatrists of South Africa" (SPSA), was legally no more than a "tea club" with no constitutional or statutory capacity to act decisively or apparently the motivation to address matters effectively [3]. Following the first democratic election in 1994, the South African Truth and Reconciliation Commission (TRC) undertook its work from 1996 to 1998 with the mandate to recommend measures 'to prevent future violations of human rights' and in relation 'to rehabilitating and restoring the human and civil dignity of victims'. No psychiatrists were included in the different activities of the TRC, although the then Society of Psychiatrists of South Africa (SPSA) submitted a formal report [4]. This provided an overview of the history of the SPSA since its formation in the early 1950s and alluded to visits and reports by the WHO, the APA, the American Association for the Advancement of Science and the Royal College of Psychiatrists. After the conclusion of the TRC's activities, the SPSA was entirely reconstituted and since 2008, the association exists as the South African Society of Psychiatrists (SASOP), a non-profit, membership-driven, private company, focusing on advocacy and ensuring the interests of its members, the discipline of Psychiatry and the community. Over subsequent years relations between the SASOP, the APA and other American psychiatric institutions have not only normalized, but thrived in terms of individual academic and research collaborations not only in South Africa but across Africa, with focus also on the mental health needs of the African Diaspora. As well as collectively through the African Global Mental Health Institute and the Black Psychiatrists of

America (BPS), through the co-opting of South African psychiatrists in meetings of the psychiatric associations and colleges of the English speaking world, through support of the SASOP by the APA in co-hosting the World Psychiatric Associations' (WPA) International Congress in Cape Town in November 2016, as well as through a piloted program group membership between the SASOP and APA.

To Capacity and Beyond! The Art of Navigating Challenging Consults for Assessment of Decisional Capacity

Chairs: Samidha Tripathi, M.D., Henry Robert Bleier, M.D., M.B.A.

Presenters: Samidha Tripathi, M.D., Henry Robert Bleier, M.D., M.B.A.

Discussant: Henry Robert Bleier, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the completion of this session participants will be able to 1. Review the elements of capacity assessment.; 2) 2. Recognize various forms of capacity assessments like procedural and functional capacity.; 3) 3. Identify the need to consider capacity for self-determination as an independent concept.; and 4) 4. Practice assessment of decisional capacity with challenging ethical and moral dilemmas in simulated case vignettes.

SUMMARY:

Psychiatrists are frequently asked to assess the decisional capacity for patients admitted in a general hospital. The process for determination of capacity follows the guidelines of four "elements" laid down by Applebaum and Grisso (1). The patient must be able: to understand relevant information, appreciate the clinical circumstances and consequences of their decision, exhibit a rational process of decision making i.e., demonstrate the ability to rationally manipulate information, and be able to communicate a consistent choice regarding their decision. In addition to this framework, psychiatrists also take into account the stakes associated with the specific decision. For example, one where the patient assumes a high risk with a low probability of benefit requires a higher level of decisional capacity. This is called the "sliding-scale" approach to

decisional capacity assessments. However, decisional capacity consults often serve unwittingly as “cover” for ethical dilemmas and the associated caregiver (moral) distress posed by the patient’s decision to accept/refuse care or to stay in/leave the hospital “against the advice” of the physicians/team (2). In these situations, merely answering the consult question i.e. “the patient does/ does not have capacity,” DOES NOT “answer the consult.” For example: A patient refuses dialysis. He is deemed as “lacking capacity” to “refuse dialysis” His surrogate “tells him” to consider dialysis. He nonetheless continues to refuse. Can we “force” him to undergo dialysis, by restraining him? Another example: A patient stubbornly refuses to leave. He is deemed as “lacking capacity” to “decide to stay.” His surrogate “tells him” to leave. He nonetheless stays put. Can we have security escort him (throw him) out? Suppose he becomes violent? Keeping these capacity related consults within the above mentioned framework (Applebaum and Grisso) is impossible and rather requires a more capacious paradigm and creative thinking from the consulting psychiatrist to address the “recalcitrant” behavior and to alleviate both the patient’s and team’s distress. Through case based simulations, the session will address ethical and moral dilemmas faced during challenging capacity assessments. Using these cases as examples, participants will be introduced to the concept of capacity for self-determination and the finer nuances in assessment of decisional capacity. Participants will be actively involved during the entire presentation, first by audience polls followed by practice break-out session into small groups with case based discussions.

Treating Muslim Patients After Travel Ban: Best Practices in Using the APA Muslim Mental Health Toolkit

Chair: Rania Awaad, M.D.

Presenter: Balkozar Seif Eldin Adam, M.D.

Discussant: Farha Zaman Abbasi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will demonstrate understanding of the unique challenges facing the mental health of American Muslims; 2) Participants will summarize key disparities in the mental health

needs of American Muslims in the Post-Travel Ban era.; and 3) Participants will learn how to effectively use the APA Muslim Mental Health Toolkit in order to effectively serve their Muslim patients

SUMMARY:

Muslim Americans are currently under unprecedented stress. With the Supreme Court upholding the Travel Ban on 6 Muslim majority countries as constitutionally sound, many in the American Muslim community feel unsafe in the country they call home. They fear the unpredictable nature of an administration that often calls for erecting walls and compiling registries based on ethnic or religious identities. With the levels of Islamophobic hate crimes reaching record heights, Muslim Americans feel vulnerable to the backlash of intolerance and racism. In order to survive and successfully adjust, they require a culturally competent mental health approach. As such, the Muslim Mental Health Toolkit was developed for the American Psychiatric Association as a vital resource for all clinicians who may encounter patients struggling with these unique stigmas. The speakers have worked extensively with Muslim patients and their families in different regions of the country. They comprehensively reviewed the literature and are familiar with the religion of Islam and the culture of Muslim patients. They have different backgrounds and unique experiences. They are experienced and interested in promoting the mental health of Muslim patients. They are able to identify the feelings of isolation and alienation of Muslim patients. This wealth and varied experience with the American Muslim community will allow the speakers to discuss the development of the APA Muslim Mental Health Toolkit and guide their fellow clinicians in how to effectively use the toolkit in providing culturally congruent mental health care to Muslim patients.

Treatment of Dangerous Patients on Both Sides of the Atlantic: Comparison of the Medical-Legal Aspects of Patient Care in France, U.S., and Canada

Chairs: Sebastien Prat, Emily Gottfried

Presenters: Nidal Nabhan Abou, M.D., R. Gregg Dwyer, M.D., Ed.D., Mathieu Lacambre

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define “dangerousness in psychiatry” and “involuntary treatment”; 2) Learn and compare the different medico-legal and ethical aspects of non-consented care in three different countries (France, USA and Canada); and 3) Appreciate the impact of the custodial environment where the dangerous patient is placed, prison or hospital, and understand the treatment options offered by a detention center

SUMMARY:

Danger imposed by psychiatric patients can be defined by any situation or action in which a patient puts the lives or material belongings of other people at significant risk. Significant risk is often due to aggressive behavior secondary to mental illness. This behavior has been outlined by several well-established criteria. Most individuals with a mental illness are not dangerous. However, the majority of violent crimes carried out by patients suffering from mental illness are secondary to a state of psychosis. These patients are often hospitalized without their consent in a secure unit due to their mental state, due to risk of harm to themselves or the public and lack of insight into their mental illness. The general principle of patient autonomy still governs medical treatment, including the need for consent to treatment, prior to any intervention. However, some patients with psychiatric disorders are unable to consent to treatment due to their severe cognitive impairment rendering them unable to appreciate the benefits of psychiatric care. Needless to say, management of patients that are significant risk to themselves and others carries significant legal and ethical implications. We must keep in mind that patients who are deemed dangerous are still victims (of their own mental disorder) and are stigmatized by society (because of their mental disorder). Therefore, the need for objective and systematic risk assessment is crucial in psychiatry, as long as the appropriate tool is chosen to inform the risk of future violence. Psychiatrists must be aware of the medical-legal aspect of their practice. The balance resides in mitigating the risk and enhancing rehabilitation of these patients. The aim of this session is to draw comparison between the many medico-legal aspects of involuntary treatment for patients who are deemed “dangerous,” in France,

USA, and Canada. Several items will be addressed, such as types of treatment given to these patients, statute of being patient and inmate, and treatments offered in jail.

Trends in Pediatric Emergency Psychiatry: Barriers and Management Approaches

Chairs: Bibiana Mary Susaimanickam, M.D., Sarah Jane Grayce, M.D.

Presenter: Margaret Benningfield

Discussants: Yasas Chandra Tanguturi, M.D., M.P.H., Geetanjali Sahu, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the trends in pediatric emergency psychiatry- specifically on suicidality and serious self-harm; 2) To list 3 barriers in the systems of care when managing children in acute care setting; 3) To describe 3 elements of collaborative care approach in management of children with acute psychiatric issues; and 4) To discuss risk assessment tools for non- psychiatric providers in the emergency setting

SUMMARY:

According to the CDC, suicide is the second leading cause of death for 10-34 year olds. A rising number of children have been presenting to emergency departments with psychiatric concerns across the United States, particularly for suicidality. A recent multi-center study indicated that the annual percentage of children between ages 5-17 hospitalized with diagnoses of suicidality or serious self-harm more than doubled from 0.67% in 2008 to 1.79% in 2015. This indicates an alarming national crisis that compels further understanding. Recently a cross-sectional descriptive study was done at Monroe Carell Jr Children's Hospital at Vanderbilt Emergency Department with psychiatric chief complaints. These results showed most psychiatric visits (77%) to the ED, especially in youth 12 and older, were for suicidality (45% with ideation, 16% after a suicide attempt, and 9% for other self-injurious behaviors). We found that 37% of patients reported not having an outpatient provider. Another study has reported that the average wait time in emergency rooms for pediatric patients with primary psychiatric diagnosis is 12.97hours, mainly due to

lack of inpatient psychiatric beds. There is an increase in the wait times and length of stay in the emergency departments for psychiatric visits, which further increases the burden on hospital services. This is notable given the shortage of child and adolescent psychiatrists nationwide, including Tennessee, where there are 7 CAPs for every 100,000 children and the majority of counties have no CAPs. This interactive workshop aims to educate the audience on the barriers and burdens in pediatric emergency psychiatry on consult liaison teams in children's hospitals which includes long wait times, lack of psychiatric bed availability, cost on health care systems to name a few. It will also focus on helping attendees improve their collaborative approach like educating pediatric and emergency providers on psychiatric issues, use of tele psychiatry, utilization of urgent evaluation in outpatient set up to decrease burden in ED, thus assisting pediatric and emergency departments in managing children with acute psychiatric issues. It also will focus on developing and educating non-psychiatric providers on risk and safety assessments. We hope this workshop helps us advocate for our patients for better resource allocation and policy change to address this growing crisis.

When Do I Need to Obtain an ECG? The Practical Whats, Whens, and Whys of ECGs in Psychiatric Practice

*Chairs: Rohul Amin, M.D., Adam Lee Hunzeker, M.D.
Presenters: Aniceto J. Navarro, M.D., Jed Peter Mangal, M.D., Sarah Chang McLeroy, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the learner will be able to recognize cardiotoxic effects of psychotropics in clinical psychiatric practice.; 2) At the conclusion of this session, the learner will be able to list drug specific and patient specific characteristics placing psychiatric patients at risk for sudden cardiac death; 3) At the conclusion of this session, the learner will be able to identify triggers for obtaining ECG in psychiatric practice using the provided pocket algorithm card.; and 4) At the conclusion of this session, the learner will be able to demonstrate

basic ECG interpretation using the provided pocket card.

SUMMARY:

The clinical utility of electrocardiogram (ECG) in medicine can be of great value to the patient and the health-care delivery system. In psychiatric practice, several classes of pharmacotherapeutic interventions have effect on the cardiac conduction system and some drugs even carry black box warning by the Food and Drug Administration (FDA). ECG is a cost-effective tool in the diagnostic evaluation of many clinical scenarios such as syncope or acute chest pain for example. However, the value of ECG diminishes when obtained in healthy patients and the interpretation of such studies is fraught with pitfalls. As such, the use of ECG in psychiatric practice requires skillful and purposeful selection. Obtaining ECGs for a psychiatrist almost always requires consultation with outside provider, creating time and financial burdens for patients. Therefore, obtaining ECGs in all psychiatric patients would impractical and possibly be harmful due to issues related to cost, time burden on the patient and the psychiatrist, as well as false positives. Psychiatric residency training and real-world practice do not sufficiently train psychiatrists in the knowledge or skills needed to navigate clinical decision trees that are required to make effective use of ECGs as a tool in their psychiatric practice. While skills of a psychiatrist to interpret ECGs diminish overtime, they still have to know and understand the timing and settings for obtaining consultation for an ECG. In this workshop, we hope to enhance the knowledge and skills of a psychiatrist in understanding triggers and decisions points regarding appropriate electrocardiographic evaluation in their psychiatric practice. These skills are important for optimal patient care and the fundamentals can be delivered to practitioners in a nominal amount of time. In this highly interactive workshop, the data and decision points are based on over forty APA, ASAM, NICE (UK), and Canadian clinical practice guidelines relevant to this topic that are distilled into a user-friendly pocket algorithm card. Audience will be provided link to the workshop content including slides, ECGs, cases, and pocket algorithm card for future use and to take back to their organizations for

dissemination to colleagues, residents and medical students.

Women's Health in the U.S.: Disruption and Exclusion in the Time of Trump

Chair: Nada Logan Stotland, M.D., M.P.H.

Presenters: Gail Erlick Robinson, M.D., Carol C. Nadelson, M.D., Gisele Apter, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the nature and importance of current threats to women's health in the USA; 2) Debate the potential positive and negative effects of the #MeToo movement; 3) Treat patients suffering from the ill effects of sexual harassment and abuse in the workplace; 4) Advocate for constructive change in national and state laws affecting women's health; and 5) Educate students, trainees, and the public about the impact of laws restricting reproductive rights and reproductive health care

SUMMARY:

These are challenging times. As of this writing, in September 2018, the United States has a President who brags about the abuse of women, condones violence against dissenters, and makes decisions that threaten the safety, even the survival, of the world. Our legislatures are stripping away women's access to contraception, abortion, and general health care. As a result, the lives and work of many of us, and of our patients, are compromised by anxiety and depressive symptoms. A New Yorker cartoon depicts a doctor telling the patient sitting on the examining table that the patient's problem is that he is paying attention to what is going on. Our leaders have unmasked and exacerbated hostile attitudes towards women and ethnic, racial, and sexual minorities. Over 12,000 immigrant children are in government detention. Women in the public eye receive internet threats of rape and murder. Women and minority workers are still paid significantly less, and promoted less, than men doing the same jobs. At the same time, most lack paid parental leave and affordable, accessible child care. The times are particularly hard on reproductive rights and care. Many Planned Parenthood clinics offering thousands of women their only health care have been shut

down. Some states have conferred personhood rights on fetuses, prosecuting and incarcerating some women for behaviors that allegedly harmed their unborn children, and forcing unwanted obstetrical interventions on others. Some states require physicians to give misinformation about contraception to schoolchildren and misinformation about abortion to pregnant women. Every one of these attacks affects disadvantaged women more severely. There are no parallels to these requirements, interventions, and punishments that apply to men. Some positive developments have downsides. #meToo has enabled some women to report sexual harassment and abuse. Some powerful men have been chastised, but that does not protect the millions of women still living and working in abusive situations that erode their self-esteem, depress their moods, and constrict their careers. #meToo could reinforce the idea that women are passive and helpless. While there is little or no support for many women who want to breastfeed, there can also be unwarranted pressure on women who don't. Equipped with knowledge about what's happening, and the ramifications for our well-being, we can use our expertise in medicine and human emotion, cognition, and behavior, to support each other, treat our patients, educate the public, and influence our leaders. Whatever the developments by May 2019, four leaders in women's health, including experts from Canada and France, will engage with the audience in a lively interchange of current information and real-life applications.

Sunday, May 19, 2019

A Basic Income: Promises and Perils for People With a Psychiatric Disability

Chair: Kunmi Sobowale, M.D.

Presenters: Annie Harper, Catherine Thomas, Evelyn Forget

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand the concept of basic income; 2) At the conclusion of this session, the participant will be able to identify how basic income may benefit patients with mental disorders; 3) At the conclusion of this session, the

participant will be able to understand barriers to inclusion of patients with mental disorders in basic income pilot demonstrations; and 4) At the conclusion of this session, the participant will be able to propose policy solutions to promote inclusion of patient with mental disorders in the basic income movement

SUMMARY:

People with mental illness are more likely to be impoverished compared to people without mental disorders (1). Even with social security and disability benefits, many people with mental illness struggle to make ends meet. Financial difficulties make it difficult for patients to meet their basic needs, to cope with financial emergencies, and to plan for irregular larger than normal expenses. Some struggle to afford psychiatric and non-psychiatric medical care and medications. This contributes to the onset and worsening of symptoms of multiple psychiatric conditions including depression, anxiety disorders and schizophrenia, and can cause or exacerbate physical health problems. Basic income, a regular payment of cash with no strings attached to cover basic needs, is one potential solution for poverty. Basic income has received liberal and conservative support leading to pilot demonstrations across the globe. These demonstrations find decreases in depression, anxiety, suicide, and hospitalizations (2,3). Unfortunately, many demonstrations have excluded people with mental disorders. Our session will empower clinicians to understand basic income and propose inclusive solutions. We will introduce participants to basic income through rapid fire talks from an interdisciplinary expert panel (anthropology, economics, and social psychology) which will cover both enthusiastic support for the concept, and more critical views. Then attendees will break up in groups to brainstorm policy solutions. Finally, solutions will be shared with experts, who will provide feedback.

A Suicide-Specific Diagnosis?

Chair: Hal S. Wortzel, M.D.

Presenters: Thomas Joiner, Skip Simpson, Morton Mayer Silverman, M.D., Igor I. Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will learn best

practices for suicide risk assessment; 2) Attendees will learn best practices for suicide risk management; 3) Attendees will learn about proposed suicide-specific diagnoses; 4) Attendees will learn potential benefits and perils associated with suicide-specific diagnoses; and 5) Attendees will participate in a forum to explore the risks and benefits of introducing a suicide-specific diagnosis

SUMMARY:

Suicide risk assessment and management remains a daunting task. Arguably, now more than ever, clinicians, families and communities are making both independent and coordinated efforts to address the ongoing problem of suicide. Yet we have made little in the way of progress in terms of lessening the frequency of death by suicide. Such deaths represent clinical tragedies, frequently impact communities at large, and are often a source of adverse medicolegal outcomes for the healthcare systems and professionals that render care. The gravity of this public health issue warrants ongoing efforts to improve suicide risk assessment and management, including novel approaches to the problem. Certainly, the idea of suicide-specific diagnoses represents a new approach, and one worthy of further discussion and consideration. New diagnostic entities have been proposed, with arguments suggesting clinical and medicolegal advantages attendant to such. Others have expressed concern regarding potential unanticipated consequences and that the proposed suicide specific diagnoses are not ready for clinical applications. This panel will explore this topic from both perspectives.

Academic Psychiatrist Seeks Community Mental Health Clinic for Long-Term Relationship

Chairs: Anna Kostrzewski Costakis, M.D., John Q. Young, M.D., Ph.D.

Presenters: Matthew Boyer, M.D., Christopher Luccarelli, Samuel Lim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify foundations for a community mental health clinic model to survive in the current economic and political climate.; 2) Explore barriers for academic psychiatry in a community setting.; 3) Demonstrate a clinician-

driven approach to improve access and sustainability of a community mental health clinic model while prioritizing an academic, trainee-focused approach.; and 4) Identify how the future direction of mental health services, particularly in New York State, will influence the evolution of the community clinic model while maintaining a rich, academic environment.

SUMMARY:

In one corner, there is the corporate, financial stakeholder dangling the money strings of sustainability for a clinic. In another corner is an academic department attempting to promote research and education in addition to patient care. In another corner are the trainees, eager to learn yet confused by a system in which their mentors are torn between interests of patients, education, research and the financial mandates of stakeholders. Enter the community psychiatrist, attempting to negotiate all these components and not burn out... what a task! In today's world of community psychiatry within an academic setting, there are numerous stakeholders pulling at our sleeves. Navigating these competing interests while ensuring the sustainability of a clinic in an ever-changing political and economic landscape is not a small task. In this session, the speakers will identify these competing interests and explore some strategies to mitigate these perils. Additionally, the speakers will use a recent pilot to illustrate the tensions in designing a community clinic around the principles of patient-centered open access, team-based coordinated care, financial sustainability, and faculty and learner development. Attendees will discuss the open access clinic model in a community setting and strategies they've found effective in its implementation in various community settings. The panel will solicit the experiences of the audience and explore strategies they've used to tackle these various challenges. Finally, the session will aim to explore future directions in the marriage between academic and community psychiatry. The speakers in this session will include a medical director of the outpatient division of an academic department, a residency program director and vice chair for education, a chief resident, a third year resident and a medical student who have all been collaborating with each other in re-designing a community mental

health clinic setting to optimize sustainability, access, patient and physician satisfaction all while providing a supportive and academically-stimulating teaching environment for trainees.

Accelerated Resolution Therapy (ART)-Based Intervention in the Treatment of Acute Stress Reactions During Deployed Military Operations

Chairs: Olli Toukolehto, M.D., Wendi M. Waits, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the challenges relating to the delivery of trauma-focused therapy during deployed military operations; 2) Review the therapeutic principles and evidence for the use of Accelerated Resolution Therapy (ART); 3) Explain how an ART-based intervention was delivered to eight soldiers within 96 hours of a traumatic event in a deployed environment; and 4) Understand how emerging brief trauma-focused therapies can treat acute stress reactions despite significant resource limitations

SUMMARY:

The treatment and resolution of psychological traumas during military deployments directly supports medical readiness, the military mission, and potentially prevents symptom progression to Posttraumatic Stress Disorder (PTSD). However, current evidence-based trauma-focused psychotherapies can be difficult to employ during deployed military operations due to various barriers. Deployed military behavioral health providers need an effective trauma-focused intervention that is suitable for the operational environment. In this presentation, we describe how Accelerated Resolution Therapy (ART), an emerging trauma-focused psychotherapy, was pivotal in the treatment of acute stress reactions in eight deployed U.S. Army soldiers. ART can be conceptualized as a hybrid of several evidence-based psychotherapy techniques. In brief, ART is a manualized, procedural adaptation of Eye Movement Desensitization and Reprocessing (EMDR) that incorporates mindful awareness of emotions and sensations, bilateral eye movements, imaginal exposure, desensitization, visual and cognitive re-scripting, and gestalt-style conversations for the processing of traumatic

experiences. The eight soldiers in this case series received one session of an ART-based intervention in the aftermath of a traumatic death. All of the treated soldiers reported rapid improvement in both depressive and acute stress symptoms. The therapeutic benefits were sustained at one month post-treatment despite continued exposure to deployment-related stressors and military operations; furthermore, a review of the medical records at one year post-incident revealed that none of the treated soldiers required further treatment for the traumatic event. Based on these encouraging preliminary findings, the authors recommend that behavioral health providers who are preparing to deploy become familiar with ART or related interventions in order to have the confidence and the skills that are needed to provide timely and effective trauma-focused care for deployed soldiers.

Addressing Microaggressions Toward Sexual and Gender Minorities: Caring for LGBTQ+ Patients and Providers

Chair: Lawrence M. McGlynn, M.D.

Presenters: Ripal Shah, M.D., M.P.H., Daena L.

Petersen, M.D., M.A., M.P.H., Neir Eshel, M.D., Ph.D., M.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the topic of microaggressions as it relates to the current practice of psychiatry.; 2) Brainstorm effective methods of processing LGBTQ+ microaggressions experienced in the workplace.; 3) Discuss the increasing need for LGBTQ-sensitive training in the health care system.; and 4) Explore innovative strategies for improving the conversation with patients, students, residents, and faculty, about the LGBTQ+ community.

SUMMARY:

In the polarizing sociopolitical climate of today's America, differences in identity and the experience of otherness are becoming an increasingly pressing feature of mental health care, both for patients and providers. With the historic marginalization of the LGBTQ+ community taking a resurgence in recent political discourse, the importance of teaching the next generation of psychiatrists how to provide LGBTQ+ sensitive care is becoming more urgent, but

comes with the backdrop of an increase in overt intolerance towards members of the community. In this workshop, we will discuss case examples of microaggressions faced by LGBTQ+ patients, medical students, residents, and faculty, in an effort to discuss ways in which to address these in a clinical interaction. We will briefly discuss the concepts of minority and majority identity development, intersectionality, microaggression theory, minority stress theory, structural discrimination, and creative resistance and resiliency. We will review key pedagogical concerns in teaching patients and peers about LGBTQ+ sensitive communication styles, such as reconciling the desire to convey content with the need to respect the affective potency of these topics. As part of this workshop, participants will have the opportunity to consider the challenges of working with those who discriminate against openly identifying members of the LGBTQ+ community, while understanding the ways in which the psychiatric community can provide support towards patients and one another when experiencing these microaggressions.

Advances in the Understanding and Treatment of Treatment-Resistant Depression

Chair: James W. Murrough, M.D.

Presenters: Andrew H. Miller, M.D., Martijn Figeo, M.D., Katherine Narr

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the major clinical and scientific issues in identifying the etiology of treatment resistant depression, including the role of neurobiological and inflammatory factors; 2) To demonstrate a knowledge of new pharmacotherapeutic approaches to the treatment of treatment resistant depression, and the current state of drug discovery; 3) To appreciate the specific role of inflammation in driving treatment resistant depression and how novel approaches are targeting this system to discover new treatments; 4) To understand the state of field concerning deep brain stimulation (DBS) and electroconvulsive therapy (ECT) for the treatment of treatment resistant depression; and 5) To compare and contrast DBS, ECT and ketamine in terms of clinical efficacy and mechanisms of action, and to appreciate the utility

of targeting specific symptoms in the treatment of depression

SUMMARY:

Major depressive disorder (MDD) is a primary cause of disability in the U.S. and worldwide. Current, commonly utilized treatments are not effective in a substantial group of individuals who may be described as suffering from ‘treatment-resistant depression’ or ‘TRD.’ As a group, these individuals tend to suffer a chronic, more severe course of illness, utilize the majority of health care resources devoted to the treatment of depression, and are at elevated risk for suicide. Contributing to the problem of limitations in treatment, there continues to be uncertainty in the field regarding the fundamental causes and mechanisms of depression. In order to address these major public health issues, the current general session will explore and describe critical current topics in the understanding and treatment of TRD through four expert faculty speakers. The following topics (and presenting faculty members) will be included in this session: (1) Next Generation Antidepressants: Novel Mechanisms and Rapid Efficacy (Dr. James Murrough, Icahn School of Medicine at Mount Sinai), (2) Inflammation and Treatment Resistance: Mechanisms and Treatment Implications (Dr. Andrew Miller, Emory University), (3) Deep Brain Stimulation for Refractory Depression: New Targets, New Hope (Dr. Martijn Figee, Icahn School of Medicine at Mount Sinai), (4) Ketamine and Electroconvulsive Therapy (ECT) for Targeting Apathy, Anhedonia, and Suicidal ideation (Dr. Katherine Narr, Geffen School of Medicine at UCLA). Expanding on this schedule, the session will begin by educating the audience on cutting-edge advances in pharmacotherapy with novel mechanisms of action and rapid onset of action. These will include not only the glutamate NMDA receptor antagonist ketamine, but also other glutamate-targeted antidepressants that are currently in development. Building on this theme, the second talk will review the current evidence for inflammatory mechanisms of MDD in general, and of in TRD in particular, and discuss with the audience the specific treatment implications of these findings. Moving from pharmacotherapy to neuro-stimulation, the third talk will teach the audience about the newest advances in the techniques and

clinical outcomes of deep brain stimulation (DBS) for TRD. Rounding out the session, the fourth and final talk will compare, contrast, and expound on ketamine and ECT for targeting specific core symptoms in TRD, including apathy, anhedonia, and suicidal ideation. To wrap up the session, the faculty will take part in a panel discussion and question and answer session with the audience moderated by the session chair that will provide ample time for audience participation. At the conclusion of this session, participants will be able to understand several of the current key issues in the understanding and treatment of MDD and TRD, as described in more detail in the session Learning Objectives.

Advocacy and Practice Recommendations for Navigating Systems of Care for Young Adults and Families Impacted by Autism Spectrum Disorder

*Chair: Taiwo Babatope, M.D., M.B.A., M.P.H.
Presenters: Vanessa H. Bal, Ph.D., Jeremy Veenstra-VanderWeele, M.D., Bryan H. King, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand life course impacts of developmental disabilities during adolescence and adulthood, including effects on the individual and on the family; 2) Identify factors that promote a positive transition to adulthood for individuals with autism spectrum disorders; 3) Identify the role of the Psychiatrist and the caregiver during transitions; and 4) Recognize opportunities for advocacy within complex systems to navigate successful transition to adult services

SUMMARY:

Although autism often is thought of as a childhood disorder, the condition is lifelong. Adolescents transitioning to adulthood are usually presented with challenges, and this period tends to be an upheaval for most individuals and their families. Appropriate and affordable services available to this population are usually constrained by funding limitations and a dearth of professionals appropriately trained to work with adults with ASD. This eventually results in many of these individuals and their families experiencing high levels of unmet needs and struggling to navigate the transition

process largely by themselves. The availability of an Individualized Education Program plan (IEP) under The Individuals with Disabilities Education Act (IDEA) ensures that eligible youth receive special education and related services prior to the 21st birthday or 22nd birthday. However, the onus lies on the advocacy powers of the families and health care professionals to access required services and navigate systems of care beyond graduation. This type of planning may involve options such as college, employment, vocational training, life skills training, and residential opportunities since studies have shown that the ability to maximize participation in higher education, employment and independent living could be effective in improving participation in adult life. This workshop will address the impact ASD has on young adults and their families. We will share common examples of the struggles experienced by the caregivers in accessing necessary services and identify factors necessary to achieve a positive transition from adolescence to adulthood. Participants will be taught about effective advocacy approaches and provided with information regarding the role of the psychiatrist in assisting these individuals as they navigate systems of care. The speakers in this workshop will include a researcher who has conducted longitudinal studies highlighting the impact of ASD on families, a family advocate, and 2 other psychiatrists who have extensive clinical and research experience in managing ASD individuals in major academic medical centers.

Advocating for Advocacy: Bringing Advocacy Into Resident Education

Chair: Samuel Robert Murray, M.D.

Presenters: Ana Holland, Rachel Robitz, M.D.,

Christina Bourne, Rachel B. Mitchell, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe advocacy as it relates to the field of psychiatry.; 2) Compare and contrast three different forms of advocacy.; 3) Identify an area within participant's professional setting where principles of advocacy discussed in this session could be applied.; 4) List two to three potential barriers to advocating for change within psychiatric settings and a strategy to overcome each of these barriers.; and

5) Feel empowered to participate in advocacy as it relates to their professional setting.

SUMMARY:

Psychiatrists are often faced with barriers that prevent their patients from accessing and engaging in appropriate care. These barriers occur on many levels, ranging from barriers specific to an individual clinic, a health care system, a community, a state or on a National level. Facing such barriers can bring a feeling of powerlessness and lead to increasing burnout. Advocating for positive change at any level could be a way to fight against that feeling of powerlessness and decrease burnout [1]. In order to adequately care for the mental health needs of the individuals who they serve, some providers find themselves taking on advocacy roles. The medical educational system has done an excellent job in training psychiatrists to diagnose and treat mental illness on an individual basis, but there are only few examples in the scientific literature of psychiatry training programs providing formal education on making larger scale change and addressing systemic barriers. While the Accreditation Council for Graduate Medical Education (ACGME) requires that Psychiatry Residents be trained to "advocate for the promotion of mental health and the prevention of mental disorders" and "advocate for quality care and optimal patient care systems" [2], there is no evidence that many psychiatry training programs offer formal rotations in health advocacy. When there is formal advocacy training, it is variable [3]. This session aims to discuss how advocacy can be introduced into resident education both formally and informally. This general session will provide an overview of advocacy on a variety of scales and in multiple settings. It will provide examples of psychiatry residents' real world advocacy projects including successes, failures and troubleshooting. Panelists will discuss advocacy projects in various settings including a residency training program, a healthcare system, a community, the APA and on a state legislative level. The session will also provide an experiential component where attendees will participate in breakout groups where they will have discussion about introducing an advocacy project into resident education and then discuss with the group at the closing of the session.

American Psychiatric Association Medical Student Elective in HIV Psychiatry: Recruitment, Mentorship, and Clinical Experience

Chair: David Tran, M.D., M.P.P.

Presenters: Patrick Sheppard, Luke Wallace Carson, M.D., Ripal Shah, M.D., M.P.H., Lawrence M. McGlynn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the value of pipeline programs in establishing mentor relationships; 2) Illustrate core topics in HIV psychiatry through case studies authored by medical student program participants; and 3) Recognize the importance of early recruitment of minority medical students who have a primary interest in services related to HIV/AIDS and its relationship to the mental health of ethnic minorities

SUMMARY:

The American Psychiatric Association's Medical Student Elective in HIV psychiatry was started in 2004 to provide minority medical students with a unique opportunity to gain in-depth knowledge and clinical experience and to develop long-lasting mentorship. Over the course of 14 years, a total of 111 medical students have been selected to participate in the elective. The program includes a three-day intensive training program in Washington, DC that covers topics such as neuropsychiatric complications, stigma, mood disorders, and substance use disorders that are associated with HIV. Travel, lodging, and a stipend are provided by the APA. After the orientation, students travel to their clinical sites where they work one-on-one with their assigned mentor for one month. The heart of the program is in establishing a mentor relationship to encourage medical students toward high achievement in the area of HIV-related mental health research or psychiatric services. Some of the students who once participated in the program have now returned as mentors. Current participating institutions include Beth-Israel Medical Center, Callen-Lorde Community Health Clinic, the Cambridge Health Alliance, Columbia University, Stanford University, and the University of California at San Francisco and the San Francisco Department of Public Health. In this session, participants will

learn about the importance of a pipeline program for early recruitment of minority medical students who have a primary interest in services related to HIV/AIDS and its relationship to the mental health of ethnic minorities. In addition, this session will include a panel of previous medical students, residents, and mentors to offer participants an opportunity to learn more about the elective and the important role of mentorship. Participants will also learn about core topics in HIV psychiatry through case studies authored by medical student program participants.

Applying Emerging Digital Health Technologies to Address Equity, Mental Health and Substance Use Disparities for Vulnerable Adolescent Populations

Chair: Niranjan S. Karnik, M.D., Ph.D.

Presenters: Marina Tolou-Shams, Ph.D., Kara Bagot, M.D., Eraka P. Bath, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to demonstrate an understanding of emerging technologies used in mental health and substance use treatment.; 2) At the conclusion of this session, the participant will be able to differentiate between the various terminologies that are used in the field of digital mental health.; 3) At the conclusion of this session, the participant will demonstrate an understanding of the existing evidenced based technologies for mental health and substance use treatment for at risk youth.; and 4) At the conclusion of this session, the participant will demonstrate an understanding of the potential applications for text message based platforms for justice involved youth and homeless youth.

SUMMARY:

Mobile health (mHealth) technologies have been increasingly demonstrated as efficacious, low-cost ways of reaching underserved, vulnerable, populations to engage them in, and/or deliver, quality care. Recently eHealth (web-based technologies for health) and mHealth (mobile devices for health) have been demonstrated to create opportunities to engage at-risk populations in HIV prevention and the promotion of recovery and

relapse prevention from substance use. Another study that focused on using a cellphone-based program to reinforce the skills taught in an aftercare program for youth on probation found that juveniles who participated in the class, followed by cellphone coaching, had lower rates of recidivism than comparable juveniles who did not receive the cellphone-based program. Recently, the FDA has recognized the role that digital health can play in reducing inefficiencies and cost, and improving access and quality and personalization of health care delivery. Mobile health thus represents a promising approach to improving psychiatric and substance use outcomes for homeless youth, court-involved youth and youth on probation, and commercially sexually exploited youth, all high-risk, vulnerable groups of adolescents with well-documented, multi-morbid health disparities and needs in the settings of limited social supports and structure. First, we will provide an overview of existing evidenced based treatment interventions and strategies that use mobile technologies and digital health for substance use and mental health treatment. We will present findings from: 1) research studies on smartphone-based interventions for homeless youth and 2) several recent pilot trials with youth on probation and commercially sexually exploited youth that use mHealth technologies (e.g., SMS text messaging, apps, biosensors) to increase access to and engagement in mental health and substance use treatment.

Assessing Leadership Opportunities: A Workshop for Residents, Fellows, and Early Career Psychiatrists

Chair: Tobias Diamond Wasser, M.D.

Presenters: James Colin Rachal, M.D., Manish Sapra, M.D., Victor Buwalda, M.D., Ph.D., Luming Li, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify relevant variables to consider when assessing potential leadership roles and administrative career opportunities.; 2) Demonstrate an understanding of different pathways for continued involvement in academics and professional organizations as a component of an administrative career.; and 3) Synthesize this

information with their own personal goals and values in assessing potential career opportunities.

SUMMARY:

During training, residents/fellows must learn the knowledge and skills of psychiatric practice. However, new graduates may find the transition from trainee to independent professional fraught with practical challenges. Further, as new professionals enter the workforce, they are frequently offered leadership opportunities within clinical institutions shortly out of training, but many lack the knowledge and tools to assess the value of such leadership opportunities in administrative and academic roles in the context of their professional and personal goals. In this interactive workshop, the presenters will first introduce components of career opportunities in leadership/administrative roles that are important to consider. They will also engage in a conversation about when in the career path should someone seek out leadership opportunities and how to approach administration about these opportunities. Further, presenters will provide nationally representative data about salary, productivity, and other relevant metrics. Presenters will then describe several hypothetical career options which incorporate leadership roles. In small groups, participants will identify personally salient career considerations and determine what additional information they would require to assess each option and how this information would influence their decision-making. Finally, the presenters will discuss various pathways for continued involvement in academic and professional organizations.

Association of Academic Psychiatry Resident Curriculum Vitae Boot Camp

Chair: John S. Teshima, M.D.

Presenter: Marcia L. Verduin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the importance and purpose of a CV in professional development; 2) Identify areas for improvement in one's own personal CV; and 3) Organize an action plan to enhance your CV to best meet your professional goals

SUMMARY:

Curriculum Vitae (CVs) are critical documents for professional development. Residents are required to submit CVs when applying for fellowships, organizations and/or seeking employment. CVs provide a detailed view of an individual's experience, skills and expertise in an organized and chronological manner. A successful CV needs to be thoughtfully planned out to show the reader what the resident has accomplished and what they have to offer the organization, department or program. CVs are living documents that depend on consistent updating throughout a person's career. Therefore having an organized and thoughtful approach at the start is advantageous. This workshop provides an opportunity for residents to review their CV with experienced academic faculty mentors from across the United States and Canada. Attendees should bring a copy of their CV (hard copy or electronic) to review with a mentor, who will provide feedback and suggestions for improvements. Participants will be provided resources and examples of model CVs. This is an excellent opportunity for residents to get practical advice on their CVs and can serve as an opportunity for them to network and seek career mentorship with academic psychiatrists.

At the Crossroads: Psychiatry and Human Rights

Chair: Corina Freitas, M.D., M.B.A., M.Sc.

Presenters: George David Annas, M.D., M.P.H., John Michael Bostwick, M.D., Jessica Elizabeth Isom, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the history of political use of psychiatry and its consequences; 2) Understand the current socio-political arena requiring psychiatry to join several uncomfortable conversations; 3) Describe cases of controversial situations with which psychiatrists are faced; and 4) Demonstrate increased working knowledge of the psychiatrist's role in major social issues

SUMMARY:

War, migration and increased demand for individual independence has policymakers struggling to provide solutions. These issues as they relate to

individual freedoms and national security bring the human rights debate back to the forefront, with the psychiatric community being called upon to provide input. The current socio-political arena has forced psychiatry into several uncomfortable conversations and practices regarding human rights, such as: Don't Discriminate; The Right to Life; No Torture; No Unfair Detainment and The Right to Privacy, to name a few. Psychiatrists are experts at navigating difficult life events and are trained to remain objective in this role; however, when it comes to addressing issues that can influence social structure and political decisions, the guidelines are less clear, and, naturally, many take personal stances more often than objective ones. Psychiatrists may be unaware of unconscious bias and countertransference in their response to these issues. Many psychiatrists feel ill equipped in responding to these issues and recuse themselves from the conversation. Staying on the sidelines without giving our valuable input results in policy makers reaching psychiatrically uninformed decisions with potentially damaging consequences for current and future generations. This session will address some of the more controversial questions that psychiatrists are increasingly pushed to answer: involuntary commitment for substance abuse; risk/violence assessments and interrogation techniques; voluntary and involuntary death; and discrimination. We will also discuss intersectionality and mental health as it relates to mechanisms for increasing the burden of oppressive forces within marginalized groups. Participants will be provided with case examples of such difficult issues, to highlight these dilemmas, and discuss different viewpoints on the topics where such divergences exists. The audience will also be allowed to engage in a panel discussion following the didactic session.

Burnout: Doctors and Lawyers and Other Professionals...Oh My

Chair: Ryan C. Hall, M.D.

Presenters: Renee M. Sorrentino, M.D., Abhishek Jain, M.D., Brian K. Cooke, M.D., Ryan Colt Wagoner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will be able to compare and contrast the unique factors and

presentation of burnout across different professions.; 2) Attendees will be able to discuss the concept of vicarious trauma and how it applies to different specialties, such as lawyers (indirect exposure), law enforcement/fire (direct exposure), and doctors; 3) Attendees will appreciate the multiple roles psychiatrists can play in addressing the issue of burnout.; and 4) Attendees will be able to identify resources, both general and profession specific, to help reduce and prevent burnout.

SUMMARY:

Burnout: Doctors, Lawyers and other professionalson my There have been recent major efforts in the medical community to address physician burnout. This can be seen from the AMA's hiring of the Rand Corporation in 2013 to study physician satisfaction and its impact on patient health. In addition, psychiatrists are often asked to get involved by their county and state medical societies to help develop physician wellness programs, educate about factors leading to burnout and how to prevent it. In addition psychiatrists are often asked to educate on the topic of physician suicide and how to prevent/reduce it. Although some factors associated with physician burnout are specific to just physicians (per AMA/Rand study having to use and/or adapt to electronic health records), other factors are ubiquitous to multiple professions, such as having to deal with changing regulations, professional isolation, and concerns over loss of professional identity and autonomy. This panel will discuss the concept of professional burnout for physicians as well as for other professions, such as lawyers, business professionals, and high-risk occupational civil servants (e.g. police and fire). In addition, we will discuss potential burnout from engaging in specialized aspects of medical practice that psychiatry is more involved with, such as identifying and treating child and sexual abuse. Psychiatrist, Dr. Sorrentino, who is an expert in the treatment of pedophilia, will discuss working with offenders of such as acts and vicarious trauma exposures influence on burnout. It is hoped that by attending this lecture the participants will better be able to understand burnout and how it presents across a wide spectrum of professional populations, which will hopefully lead to better treatment, outcomes, and professional satisfaction for all.

Can Research on Childhood Trauma Revitalize Psychiatry? How Disrupting Diagnosis May Enhance Patient Engagement and Lead to Innovative Practices

Chair: Andres F. Sciolla, M.D.

Presenters: Caroline Giroux, M.D., Samuel Robert Murray, M.D.

Discussants: Carol Rung-Rung Chen, M.D., Kate Richards, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participant will be able to list three major neurobiological adaptations to adverse childhood experiences (ACE); 2) 2. At the conclusion of this session, the participant will be able to compare and contrast case formulations with and without a consideration of trauma; 3) 3. At the conclusion of this session, the participant will be able to propose changes in clinical practice to accommodate the needs of patients exposed to ACE and improve their health outcomes; and 4) 4.

At the conclusion of this session, the participant will be able to outline implications of early life stress science on future classification systems of mental disorders

SUMMARY:

Psychiatric clinicians and trainees regularly struggle as they attempt to follow diagnostic standards and treatment guidelines when dealing with patients presenting with multiple comorbid disorders or amalgams of psychiatric syndromes. These diagnostic difficulties are compounded by frequent interpersonal and communication challenges that these patients offer, and the poor treatment outcomes observed even in the presence of adequate adherence. Although survivors of childhood trauma are markedly overrepresented among these patients, research has shown consistently that clinicians often overlook trauma exposure. Moreover, research in multiple fields over the past 20 years converge to show that the emergence of mental disorders and treatment response are robustly predicted when considering the cumulative effects of multiple, co-occurring adverse childhood experiences (ACE) in the absence

of protective factors. Animal models as well as epidemiologic, basic, translational and clinical research show that dose-dependent and persistent adaptations take place in the brain and related systems as a result of ACE. Across psychiatric populations, childhood trauma prevalence ranges from frequent to nearly universal; therefore ignoring trauma is an unacceptable but wholly avoidable gap in practice given the existence of persuasive trauma-informed approaches and evidence-based therapies. This presentation will illustrate with clinical cases the negligible impact that research on ACE and resilience is having on educational, diagnostic and treatment practices in real-world and academic psychiatric settings. In addition, this presentation will use active learning and participatory techniques to engage the audience in discussing video clips depicting the lived experience of actual patients and simulated encounters with suboptimal and promising outcomes. During the Q & A section, the speakers will highlight the ways in which this presentation is responsive to the annual meeting's theme and relevant to practice and education in underserved and public psychiatry settings. The speakers believe that patients presenting with diagnostic challenges signal the need to elicit comprehensive histories of trauma exposure, including historic, transgenerational and attachment trauma. From the point of trauma disclosure, this information can be used to (1) educate patients and validate their experiences; (2) identify correctly the role of trauma in health risk behaviors, communication challenges with healthcare providers, and diagnostic dilemmas; and (3) engage patients effectively in shared decision-making to maximize adherence and treatment outcomes.

Can We Tailor Care for Children With Autism Spectrum Disorder?

Chair: Gisele Apter, M.D., Ph.D.

Presenters: Nicole Garret-Gloanec, Alexandra M. Harrison, M.D.

Discussant: Gisele Apter, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize how to facilitate access to care for hard-to-reach families with very young children with ASD; 2) Identify appropriate

integrative interventions for very young children with ASD in a public health care setting; 3) Review and learn how to choose programs tailored to each child with ASD's individual needs; and 4) Practice recognizing micro-analytic modifications in non-verbal interactions between adult and child during therapeutic interventions

SUMMARY:

We aim to illustrate options in tailored care internationally for young children (preschool) with Autism Spectrum Disorders (ASD). The organization of child and juvenile psychiatry in France is under the responsibility of the Ministry of Health. It was built to make services freely available to the entire population. Access is open to all children and adolescents up to 18. Its main aims and objectives range from secondary and tertiary prevention to diagnosis and care for children, guidance and educational support to families including network with partners and support for expertise training of other health professionals. The children are referred for diagnosis. Planning of care project course coupled with orientation according to specific family and child characteristics are then implemented. The majority of children are followed up in out-patient clinics exclusively. A small percentage, mainly children with ASD, may receive care in the form of multi-disciplinary interventions, integrated as part of day hospitalisation (about 10 - 15 hours on average per week). The majority of children with ASD enrolled in intensive care programs come from families with low socio-economic backgrounds requiring first stage of care before being referred to other special needs educational or social institutions. Interventions are defined and implemented following functional and psychopathological analysis that are formalized in a document during a process of pre-registration. These modalities have clinical research validated characteristics for children with ASD that could be usefully generalized. How the program adapts to each individual child, tailoring integrative care specifically while maintaining essential objectives due to ASD developmental challenges will be presented. We wish to highlight the originality of the process that creates a "customized" plan for each individual child. Thus, each child benefits from an individually tailored hands-on program that promotes better individual

trajectories than a fit-for-all program even if based on general knowledge of ASD. These modalities could open options for more individualized care, within a framework of public health policy focused on the most disadvantaged children with ASD. While much progress has been made using behavioral methods for teaching language and life skills to children with ASD, the psychodynamic treatment of these children is more controversial. Insights from infant research are helpful in treating patients with “quirky” minds, or atypical ways of making sense of their worlds. Developmental models that provide a framework for the essential nonverbal interactions of two individuals communicating with each other are particularly useful. We will use videotape and microanalysis of clinical material from the analysis of a 4-yo boy to illustrate methods of meeting the mind of a child with autism and to demonstrate the value of these insights in understanding therapeutic action.

“Catch Me If You Can”: Catatonia in General Medical Settings

Chairs: James K. Rustad, M.D., Vineeth John, M.D., M.B.A.

Presenters: Devendra Singh Thakur, M.D., H. Samuel Landsman, M.D., William Tate Schleyer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the overlap and relationship between delirium and catatonia in medically-ill patients.; 2) Understand that neuroleptics, often used to manage hyperactive delirium, may precipitate malignant catatonia.; 3) Understand that benzodiazepines, first-line treatment for catatonia, may be deliriogenic.; and 4) Discuss the false dichotomy of the historical distinction between catatonia and delirium

SUMMARY:

Catatonia and delirium share several clinical features, including altered activity, behavioral dysregulation, and fluctuations in cognition. Delirium is frequently considered on the differential diagnosis for catatonia, however, the differential for delirium rarely includes catatonia. Rapid identification and treatment of catatonia is essential to avoid progression to a life-threatening malignant catatonic

state. Precise diagnosis of altered mental status is essential, as treatments of hyperactive delirium (e.g., antipsychotic medications using the mechanism of dopamine antagonism) can worsen catatonic conditions and lead to malignant catatonia. Our workshop will use case-based learning to guide participants in the evaluation and management of catatonia in acute medical settings. We will review the work-up of altered mental status and discuss subtle differences between delirious and catatonic clinical presentations using case-based methods. We will demonstrate the performance of the standardized examination of catatonia (Bush-Francis Catatonia Rating Scale (BFCRS)) and assessment tools for Delirium (e.g., Confusion Assessment Method, Confusion Assessment Method for the ICU).

Children of Psychiatrists

Chair: Michelle B. Riba, M.D., M.S.

Presenter: Steven G. Dickstein, M.D.

Discussant: Patricia Isbell Ordorica, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To discuss the impact on a child of having a parent who is a psychiatrist; 2) To review some experiential examples of having a parent is a psychiatrist, such as friends who might be patients of one's parent; and 3) To review some cultural similarities and differences of children who were raised by psychiatrists in different countries, or nationalities

SUMMARY:

The interest of the impact of one's career and profession on our children is important and interesting. For the last 20 years, we have presented this workshop to standing room only audiences. We have also asked how to present this workshop in other countries, at national psychiatric meetings. We ask psychiatric colleagues to discuss with their children who might want to present their experiences and then in a lively question and answer format, the audience directly ask the children for input and advice. We also welcome audience participation for those who themselves were children of psychiatrists. This workshop is often viewed as one of the most fun and beneficial

sessions and we are very pleased and honored to submit this workshop for presentation. Interestingly enough, not much has been written about this particular subject in the literature, so therefore, these workshops form a way for colleagues to connect on an experiential level.

Cognitive Behavior Therapy for Anxiety Disorders

Chair: Donna Marie Sudak, M.D.

Presenters: Judith Beck, Ph.D., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Describe the cognitive formulation of anxiety disorders.; 2) 2. Detail CBT behavioral strategies that are key interventions in the treatment of anxiety disorders.; and 3) 3.

Describe CBT techniques to modify anxiety provoking cognitions

SUMMARY:

In this workshop, methods are described and illustrated for drawing from the theories and strategies of CBT to treat anxiety disorders. With a focus on panic disorder and social anxiety disorder, specific interventions are detailed including psychoeducation, targeted behavioral methods, and cognitive restructuring. Participants will have the opportunity to discuss how they could implement CBT for anxiety disorders in their own practices.

Collaborative Care for Serious Comorbid Medical and Psychiatric Illness: Lessons on Integration From the HIV Epidemic

Chair: Francine Cournos, M.D.

Presenters: Marshall Forstein, M.D., Karen McKinnon, M.A., Christina V. Mangurian, M.D., Daria Boccher-Lattimore

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Cite the pros and cons of different integrated/collaborative care models for treating people with serious comorbid medical and psychiatric illness; 2) 2. Understand lessons learned in the HIV epidemic about integrating care for people with HIV/AIDS and serious psychiatric illness; 3) 3. Learn strategies from audience members' experiences with the strengths and

weaknesses of care integration models for serious comorbid medical and psychiatric illnesses; and 4) 4.

Brainstorm clinical, research and policy ideas for expanding our models of care for this population

SUMMARY:

How can we best integrate care for people with serious psychiatric illness and serious medical illness? What are the limits to providing psychiatric care in medical settings and the limits of providing medical care in psychiatric settings? And how do we train the workforce for their roles in complex integrated care settings? At present, the collaborative care model offers guidelines for providing mental health treatment for mild to moderate psychiatric illness in primary medical care settings, and medical treatment to people with moderate to severe mental illness in mental health settings. But caring for people who have both serious medical illness and serious psychiatric illness takes us beyond the usual boundaries of this model. The HIV epidemic provides a good example of the innovations needed to rise to this challenge. Early in the epidemic, when there was no effective HIV treatment, very ill psychiatric patients migrated into the HIV care system because psychiatric settings were ill at ease with providing end-of-life care. When effective HIV treatment became available, there were ever changing guidelines for when to begin treatment and which medications to use, fostering a continuation of utilizing medical settings for integrated care. Today, HIV infection is a chronic disease with better established treatment guidelines, and HIV care is now migrating into non-specialized primary care. However, psychiatric settings remain slow to expand their capacity to provide HIV services. Our presenters have extensive experience at the interface of HIV infection and mental illness. We will discuss the facilitators (e.g. struggle to contain an epidemic; development of specialized funding streams) and barriers (e.g. difficulties recruiting psychiatrists) to the provision of care for people with serious psychiatric illness within HIV medical care. We will examine the pros (e.g. mental illness stigma reduction for both providers and patients) and cons (e.g. limited range of psychiatric services) of treating serious psychiatric illness in a medical setting. We will describe

comprehensive HIV programs that have achieved considerable success with care integration, and outline a unique education and training approach to preparing the health care workforce for successful collaboration. Interactive techniques will be employed to elicit audience members' experiences with integrating care for people with comorbid serious medical illness and psychiatric illness. What care models are attendees using? Are there examples of providing care for other serious medical illnesses that we can learn from? How are we training psychiatrists and other health care providers to provide complex integrated medical and psychiatric care? To conclude, audience members and presenters will brainstorm about innovative clinical, research and policy directions to expand our integrated/collaborative care approaches.

Communicating Through Brains: Measuring and Modulating Brain Network Communication for Diagnosis and Treatment

Chair: Alik Sunil Widge, M.D., Ph.D.

Presenters: Vikaas Sohal, Amit Etkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of electrical brain oscillations in establishing communication within brain networks.; 2) Describe how brain oscillations and rhythms may become disrupted across many mental illnesses.; 3) Describe new technologies for measuring brain network function, including imaging, EEG, and direct stimulation.; and 4) Describe ways in which neurostimulation technologies may be used to change brain network function.

SUMMARY:

Mental illnesses, from depression to obsessive-compulsive disorder to addictions to schizophrenia, are increasingly understood as circuit illnesses. We recognize that our patients' symptoms arise from breakdown of information processing in widely distributed brain networks. Modern neuroscience, both animal and human, has yielded tools to measure and potentially repair those network communication processes. This session will describe those tools, with an emphasis on methods and ideas that are in or nearing clinical trials. Amit Etkin will

describe the use of functional neuro-imaging to measure brain networks and to identify phenotypes that cut across diagnoses, and will show how transcranial magnetic stimulation (TMS) can more precisely probe those networks. Vikaas Sohal will describe the role of electrical brain oscillations in establishing network communication, both in models of schizophrenia and, more recently, in human patients with depression. Alik Widge will expand on this oscillatory discussion to show methods of changing brain network communications by electrical brain stimulation by targeting those same electrical oscillations. He will show data from an ongoing NIMH-funded brain stimulation trial demonstrating successful network modulation in obsessive-compulsive disorder. There will be ample time for panel discussion and consideration of the next steps towards implementing these insights in more general psychiatric practice. Taken together, these talks and the resulting discussion will make cutting-edge network neuroscience more available and accessible to our membership.

Conspiracy Theory: From the Fanatical to the Fringe and Beyond

Chair: George David Annas, M.D., M.P.H.

Presenters: Diana Kurlyandchik, M.D., Melissa K. Spanggaard, D.O., James Lyle Knoll, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use practical methods to help determine the difference between a delusion and an otherwise false belief in clinical practice; 2) Demonstrate knowledge in the characteristics, demographics, and potential motivations of so-called "Conspiracy Theorists"; 3) Learn about the psychological theories behind why people believe in conspiracy theories; and 4) Understand some of the ways to improve critical thinking in psychiatric practice

SUMMARY:

From the "InfoWars" of Alex Jones to "The Storm" of the elusive QAnon, our population is rife with followers of odd, "fringe" stories and beliefs that many commonly refer to as "Conspiracy Theories." The followers of such beliefs often hold such strong faith in them, that it can become difficult not to ask

ourselves the question “are they delusional?” While there is great diversity among such followers, it appears that the vast majority are unlikely to suffer from SMI. Yet, at what point does the intensity of- or the belief itself- become delusional? Is there even a line to be crossed- or is something else at play? This panel will address some of the most firmly held “fringe” sounding beliefs and the general psychological theories driving some to believe in them. Where do the roles of politics, bias and denial fit in? When it comes to Conspiracy Theories, are those with SMI more vulnerable to manipulation by those who spread them? This panel will also present a report of a treatment competence case confounded by the patient’s adamant belief in a cabal of world leaders worshipping at the feet of giant wooden owl (with a conclusion that you might not expect). Additionally, we will present some practical steps that a psychiatrist can take when attempting to determine when a false belief represents a break with reality, and when it is simply an odd belief with little clinical significance. The panelists include one of the top forensic psychiatrists in the field, as well as two other forensic program directors, and a highly skilled psychiatrist who has presented at a national conference on the psychology of conspiracy theorists. Thanks to the CIA, our televisions are actually listening to us; thanks to Bluetooth it’s no longer abnormal to walk down the street empty-handed and have a conversation with someone who is not there. What we consider real is continuously being challenged, reminding us that we are far from immune to our own biases leading to our own false beliefs. In the search for truth in a sea of fringe conspiracy, fake news, and governmental spying, can a critical look into the world of “Birthers,” “Truthers” and beyond help us to stay afloat?

Co-Occurring Mental Illness and Substance Use Disorders: A Guide to Diagnosis and Treatment

Chairs: Jonathan Avery, M.D., John Warren Barnhill, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the interview and assessment of individuals with co-occurring disorders; 2) Understand treatment strategies for

individuals with co-occurring disorders; and 3) Describe psychopharmacological and psychotherapeutic interventions for individuals with co-occurring disorders

SUMMARY:

The editors of *Co-Occurring Mental Illness and Substance Use Disorders: A Guide to Diagnosis and Treatment* present an evidence-based approach to patients with at least two psychiatric disorders, one of which relates to substance use. Because co-occurring disorders are more the rule than the exception in psychiatry, the editors emphasize that patients should be carefully evaluated for a broad range of disorders, which should then be addressed clinically. The range of psychiatric disorders and the number of substances of abuse create complexity that can feel overwhelming to clinicians, and the editors will address this challenge by providing straightforward strategies for diagnosing and treating people with complicated presentations.

Culture Is Psychiatry: A Hands-on Guide to Teaching and Managing Sociocultural Issues

Chair: Josepha A. Immanuel, M.D.

Presenters: Priya Sehgal, M.D., M.A., Auralyd Padilla Candelario, M.D., Justin A. Chen, M.D.

Discussant: Nhi-Ha T. Trinh, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Highlight the development, implementation of sociocultural psychiatry curricula at several different psychiatry residency training programs; 2) Recognize the challenges and opportunities teaching trainees about sociocultural issues in psychiatry; and 3) Gain hands-on experience and concrete guidelines in small-group breakout sessions on how to manage sociocultural dilemmas and micro-aggressions.

SUMMARY:

Culture is a complex concept sometimes overlooked as a useful and viable addition in the clinical setting. However, given the current divisive socio-political climate, recognizing the impact of sociocultural constructs-- race, sexuality, gender, politics, spirituality and socio-economic standing— in clinical and training settings has become increasingly

important. Thus, psychiatric clinicians must be aware how these social identities impact themselves and the patients' experience and narrative. Medical education has evolved from emphasizing cultural competence— an understanding about other cultural groups—to cultivating cultural humility— a pursuit of evaluating the relationship between the physician's and patient's socio-cultural experiences. Despite this shift, developing and teaching social-cultural psychiatry can be challenging. In this workshop, faculty from three training programs will discuss the development of a socio-cultural psychiatric curricula and provide recommendations to address associated educational challenges. Although the ACGME milestones reflect a shift to cultivating cultural humility, additional training is needed for residents and even seasoned psychiatrists to address complex cultural issues such as overt discrimination and micro-aggressions in the clinical setting. In a survey of over 800 U.S. physicians, nearly 60 percent experienced offensive comments about one's youthfulness, gender, race or ethnicity. Approximately half of those surveyed had a patient request a different doctor, or ask to be referred to a clinician other than the one their physician selected. Trainees may be confronted for the first time with the stress of addressing these complex and potentially charged topics with patients who possess contrasting viewpoints or who may outright reject a clinician from a different background. In this session, the educators will use interactive exercises to provide practical methods of bridging sociocultural issues in our current cultural state with pragmatic pedagogic techniques teaching sociocultural concepts, grappling with sensitive topics to trainees, and managing their own emotional response to such topics. Participants will be invited to gain hands-on experience--coupled with concrete guidelines-- with these topics in small groups, and will gain ideas and skills for implementation within their own institutions.

Dementia or Primary Psychiatric Disorder? Early Diagnosis and Treatment of Neurocognitive Disorders in the Psychiatric Setting

Chairs: Vineeth John, M.D., M.B.A., James K. Rustad, M.D.

Presenters: Geraldine McWilliams, M.D., Paulo Marcelo Gondim Sales, M.D., Marsal Sanches, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate the importance of early diagnosis and treatment of neurocognitive disorders presenting in the psychiatric clinical setting; 2) Examine the complexities involved in the selection of pharmacological and psychosocial approaches to treat neurocognitive disorders in these populations; 3) Distinguish the cognitive symptoms associated with mood/psychotic disorders from those pertaining to neurocognitive disorders; and 4) Discuss different protocols to assess and treat neurocognitive disorders in the psychiatric setting

SUMMARY:

Neurocognitive disorders often present with mood, personality and behavioral changes, sometimes resulting in their misdiagnosis as a primary psychiatric disorder. On the other hand, cognitive symptoms among patients with psychiatric disorders (specially mood disorders and schizophrenia) are common. Given the considerable overlap in the clinical presentation of patients with dementia and other psychiatric conditions, distinguishing both groups of patients may be challenging. Psychiatrists would benefit from a better understanding of the diverse and manifold clinical features of various neurocognitive disorders, as their accurate diagnosis is crucial for accessing appropriate treatment. This workshop will focus on a "tool kit" approach for the practicing psychiatrist with regards to critical elements in the assessment and treatment of neurocognitive disorders, such as Alzheimer's disease, Frontotemporal dementia, Dementia of Lewy Body, and Vascular Dementia. Comprehensive clinical history, relevant neurological findings, as well as typical laboratory and neuroimaging studies to help distinguish between major neurocognitive disorders and other psychiatric conditions would be discussed. Using multiple clinical vignettes, the panelists will demonstrate various "expert strategies" which could be easily utilized in clarifying the diagnosis of neurocognitive disorders. Furthermore, cognitive screening instruments such as the Montreal Cognitive Assessment (MoCA) and

the Mini-Cog will be demonstrated, highlighting their utility in clinical practice. Finally, the latest treatment algorithms for the management of cognitive and behavioral aspects of the various neurocognitive disorders will be discussed.

Designer Highs: Why Synthetic Drugs Present a Growing Concern to Psychiatrists in Multiple Settings

Chair: Vanessa Torres Llenza, M.D.

Presenters: Gowri Ramachandran, M.D., Brenna Rosenberg, M.D., Amin Memon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the “designer drug movement” and current legal status of synthetic marijuana, synthetic stimulants, and synthetic opiates. Discuss barriers to legal regulation of these products.; 2) Name examples of the psychoactive components that can be found in “Spice”/synthetic cannabis, and explain why synthetic cannabinoid use is associated with more agitation and psychosis than marijuana.; 3) Compare the clinical effects of cannabidiol containing products with those of synthetic cannabinoids.; and 4) Contrast the management of intoxication and withdrawal from synthetic opioids use with that of traditional opiates (prescription, heroin, methadone).

SUMMARY:

Synthetic drugs present a growing concern to the psychiatric community. These drugs have been chemically ‘designed’ to achieve potent highs, evade expanded drug testing and circumvent regulatory rules and laws. However, these drugs have severe, long lasting and/or often life threatening effects with a staggering potential for abuse and dependence. Synthetic drug use has been rapidly increasing in prevalence amongst high school students, with its popularity now only second to cannabis. Since 2013 the rate of synthetic opioid related deaths has increased by a factor of 6, with synthetic opioids now accounting for almost half of opioid related deaths. The hypothetical ‘honeymoon’ period- the length of time between the emergence of new drugs to the beginning of when the consequences of these drugs reach public, clinical, and regulatory attention- is over. The NIH-sponsored 2017 Monitoring the

Futures Study eloquently said, “the forces of containment are always playing catch-up with the forces of exploitation and encouragement. “ The rise in synthetic cannabis, stimulant, and opioid use is evidence of a new trend in drug use, which we call the “designer drug movement. “ This presentation explains and raises awareness about the designer drug movement, and discusses the unique challenges associated with the clinical management of these patients. Interactive discussion will be encouraged through case examples at the conclusion. Time will be given for Q&A after each presentation. Interactive discussion will be encouraged through case examples using video footage of intoxication at the conclusion, Responses will initially be collected through interactive polling, then opened to the floor for further discussion.

Developing Systems-Based Practice and Quality Improvement Competencies During Psychiatry Residency: The Problem of Suicide Prevention in the VHA

Chair: Lindsey Zimmerman

Presenter: Mark Freeman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the potential benefits of integrating systems practice and quality improvement training during residency; 2) Identify key components of iterative problem-based learning that can be applied to systems practice and quality improvement training; and 3) Synthesize systems practice and quality improvement competencies related to suicide prevention

SUMMARY:

The complexity of psychiatry practice is increasing. Addiction and mental health care occurs within the dynamics of large integrated health networks and team-based care. Today, care is delivered and coordinated over multiple platforms. Evolving electronic health records and administrative data streams bear policy, funding, and accreditation mandates to achieve high-value care for patients. Building from the ACGME core residency program standards, we propose that training in addiction and mental health care quality improvement critically informs best practices for managing patient care

across the care continuum. Training in improvement and implementation science methods focuses on making systems improvements. Systems-based practice competencies include responsiveness to the larger care system, from working within an interprofessional team to working within larger administrative and regulatory environments. Aligning quality improvement and systems practice educational goals will prepare psychiatrists to be better practitioners, and future addiction and mental health leaders. Psychiatrists are often called on to serve in leadership positions and are required to create and implement quality improvement efforts. But, formal education to integrate quality improvement and systems-practice competencies may be limited and training opportunities siloed. Our interactive session will demonstrate our synthesis of systems-based practice and quality improvement competencies using a problem-based exercise drawn from the Stanford Psychiatry residency didactics held within the Veterans Health Administration (VA). Our session problem is drawn for our semester-long curriculum, which focuses on the national VA suicide prevention initiative. We are using an iterative problem-based learning approach, in which the residents are introduced to increasingly more complex and rich information related to suicide prevention from multiple perspectives and sources. Each session of didactics include small group exercises to gather additional information and engage in a concrete activity to refine their problem definition and hypotheses about practice and system improvement strategies. As examples, residents review the relevant health system quality measures, and evaluate that state of provider and health system practice based on empirical evidence. Residents also interview health system stakeholders to learn the historical and current health system context related to suicide prevention. These stakeholders include VA consumers, providers, managers and policy makers. Learners in this session will participate in small groups and focus on a carefully crafted iterative case drawn from the suicide prevention problem. We anticipate that participants will benefit from a demonstration of the phases of problem-definition refinement, and concurrent consideration of systems practice and quality improvement.

Digital Psychiatry: The Future of Phenotyping and Treatment in Mental Health

Chair: Maria Faurholt-Jepsen

Presenters: Melvin McInnis, Justin Taylor Baker, M.D., Ph.D., Kathleen Merikangas, Maria Faurholt-Jepsen

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize and realize the widespread potential in digital psychiatry; 2) Get insight into the use and evidence of digital phenotyping; 3) Get an updated knowledge on the use of smartphones as treatment interventions; and 4) Identify and discuss different electronic monitoring tools to recommend to patients and health care providers

SUMMARY:

Deep dynamic phenotyping of individuals with severe and moderate mental illness over time presents a potential paradigm-shifting opportunity to reevaluate how we study and provide interventions to individuals as they transition between phases of illness. First, Dr. Baker will present preliminary results from an ongoing observational study combining sensor data from phones and wearables, which detect that individual's path through a complex and changing idiosyncratic environment along with surveys and voice recordings describing key ideographic events collected on the phone in a trans-diagnostic cohort of 100 individuals with early primary psychosis (i.e. schizophrenia or schizoaffective disorder) and psychosis secondary to an affective illness (i.e. bipolar disorder or major depressive disorder). Second, Dr. McInnis will present data from a study on assessment of emotion from personal and clinical assessment phone calls used to predict mood states. A database of 13,611 segments of speech (25 hours) from a longitudinal study of speech in bipolar disorder was annotated by human listeners using a 9-point Likert scale, assessing levels of activation and valence in the speech. Weekly assessment calls determined the clinical mood states of the individuals. Analyses showed that both activation and valence correlated with clinical mania and depression ratings. Dr. Merikangas will present data from a large community based family study that

employs combined active and passive mobile technologies to characterize objective dynamic phenotypes in people with Bipolar Disorder and Major Depression compared to unaffected controls. They found that people with BPD have lower levels, a shift in circadian timing and greater variability in motor activity than those with other subtypes of mood disorders or controls. People with BPD exhibit greater cross-domain reactivity in motor activity, sleep, mood, and subjective energy than those without BPD, and greater fluctuation of attention than mood over time, suggesting the mood regulation may be a less salient feature of BPD than motor activity, attention and energy. These findings have important relevance to treatment of BPD that currently focuses on mood rather than the domains identified in this sample. To emphasize the potential use of smartphones for treatment in mental illnesses, data from RCTs will be presented and discussed. Recently, the MONARCA I RCT was the first to investigate the effect of smartphone-based monitoring in patients with bipolar disorder. Findings suggested that smartphone-based monitoring sustained depressive but reduced manic symptoms. It has never been tested in a RCT whether smartphone-based monitoring including a clinical feedback loop integrating subjective as well as automatically generated objective data in patients with bipolar disorder improves illness outcome. The interesting findings from the MONARCA I and II trial will be presented and discussed with the audience at the congress.

Dilemmas in the Treatment of Narcissistic Personality Disorder, Part 1

Chair: Glen Owens Gabbard, M.D.

Presenters: Holly D. Crisp, M.D., Frank Elton Yeomans, M.D., Ph.D., Elsa Ronningstam, Ph.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To educate participants about building beginning the treatment of NPD patients; 2) To demonstrate techniques for building a therapeutic alliance; and 3) To understand the pleomorphic nature of NPD

SUMMARY:

Narcissistic Personality Disorder is a complex condition that varies in its presentation and requires flexibility in the treatment approach based on the patient's clinical picture. Beginning the treatment and building a therapeutic alliance will be illustrated with clinical examples. In addition, the varied presentations of narcissistic patients and the empirically-based subtypes will be discussed and illustrated. An overall theme in the presentation will be that treatment needs to be adjusted to the patient's particular characteristics

Dilemmas in the Treatment of Narcissistic Personality Disorder, Part 2

Chair: Glen Owens Gabbard, M.D.

Presenters: Holly D. Crisp, M.D., Frank Elton Yeomans, M.D., Ph.D., Elsa Ronningstam, Ph.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To educate participants about the psychotherapy technique useful in the later stages of psychotherapy with NPD; 2) To familiarize participants with the transference and countertransference configurations that are common with NPD patients; and 3) To illustrate the challenges of treating patients with malignant narcissism

SUMMARY:

This contribution to the program is Part 2 of Dilemmas in the Treatment of Narcissistic Personality Disorder and should follow directly after Part 1 of Dilemmas in the Treatment of Narcissistic Personality Disorder. While Part 1 focused on beginning the treatment and building a therapeutic alliance with the patient, Part 2 will describe the challenges that occur in the later phases of treatment when specific transferences and countertransferences need to be addressed. This second part will also present the challenges that occur with patients who are on the border of treatability, namely, those with malignant narcissism. Treatment strategies will be discussed and illustrated.

Disrupting the Cycle of HIV Transmission: The Role of Mental Health Providers in the Inclusive Use of PrEP to Address Disparities

Chairs: Marshall Forstein, M.D., Kenneth Bryan Ashley, M.D.

Presenters: Daena L. Petersen, M.D., M.A., M.P.H., Keith A. Hermanstyne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define PrEP (pre-exposure prophylaxis) and the ARTs (antiretroviral treatments) that are currently available for PrEP; 2) Identify populations at risk for HIV that might benefit from PrEP; 3) Understand the disparities related to the usage of PrEP; 4) Formulate a clinical situation in which PrEP might be appropriate and safe; and 5) Identify two potential adverse outcomes of population use of PrEP

SUMMARY:

HIV continues to be a worldwide epidemic. In the United States, approximately 40,000 new infections occur yearly, with the major incidence in MSM (men who have sex with men). Black and Latinx men and women are disproportionately infected. Substance use can confer increased risk of HIV infection, which needs to be considered in the context of the current opioid epidemic. People continue to participate in condomless sex despite increased access to condoms since the height of the HIV epidemic. The advent of multi-drug treatment for HIV that has increased health and longevity among those infected has also had the concurrent effect of decreasing the sense of fear and anxiety about acquiring HIV as a life threatening disease. Several studies proved antiretroviral medication effectively blocked infection by HIV if taken appropriately (pre-exposure prophylaxis-PrEP). Subsequent research indicated significant effectiveness in preventing acquisition of HIV with adequate adherence to PrEP, ultimately resulting in FDA approval. Given the enormous impact of HIV on at risk populations both the CDC and the World Health Organization recommend PrEP for “high risk” individuals who are HIV negative. These population based recommendations do not adequately assess the impact of PrEP on individuals with regards to psychological readiness, issues around access, capacity for adequate adherence,

and the potential for increasing risky behaviors. Antiretroviral therapy in people with HIV that suppresses viral replication has been shown to eliminate the transmission of HIV. However, concerns have been voiced about spending resources on PrEP rather than on treatment for those already infected, especially in resource poor environments. This workshop will include brief presentations which locate PrEP in a sociocultural context, review the science of PrEP including both successes and challenges, discuss the role of PrEP in people with substance use disorders, review the translation of the research into clinical practice, and examine the psychotherapeutic, social policy issues, and ethical implications of using costly medications in healthy people. The long term unintended consequences will be discussed as social, political, intrapsychic and public health issues. The following questions will be raised in brief presentations: 1. What role may differences in research protocols and clinical settings have on outcomes? 2-What social, psychological and financial issues must be considered from applying research findings to a specific clinical situation? 3- How will the use of PrEP affect decision making and risk taking? 4- How will resources applied to PrEP affect the access to care and treatment for people infected with HIV? 5-What are barriers to the uptake of PrEP in some at risk populations? 6-How should psychiatrists and mental health clinicians incorporate PrEP into ongoing treatment for high-risk individuals? What countertransference issues might arise?

Disruptive Psychiatry: Innovation, Administration, and Leadership

Chair: Michael T. Compton, M.D., M.P.H.

Presenter: Victor Buwalda, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the concept of disruption and its consequences; 2) Describe different forms of innovation of DHTs; 3) Describe competencies in psychiatric administration; and 4) Gain knowledge of digital leadership and how to achieve it

SUMMARY:

The world around us is changing rapidly. Several paradigm shifts (Sederer et al, 1997; Sperry et al, 1997; Hermann, 2005; Buwalda, 2013) in the last decades urge psychiatrists to change and adapt more rapidly to their professional environment so they can fulfill their changing roles in the doctor-patient relationship (Buwalda et al., 2004). Also, we need to be better prepared in today's complex society where mental health care is increasingly being made available at the point of convenience. The main question to be answered today is how we can, as psychiatrists, keep up and be there for our patients in need in this complex environment, and how can we embrace digital health technology (DHT) to help achieve our professional goals with the use of smartphone apps, VR environments, telemedicine etc. (Torous et al, 2014; Krausz et al., 2016; van Gisbergen, 2016; Saeed et al. in press). This lecture will explore the challenges of this digital era for psychiatrists. How administrative competencies can help to adapt, follow and/or initiate new digital health technology developments and show new necessary digital leadership to guide, assist and coach our patients. Also, the disruption (Christensen et al., 2015; Plsek et al., 2014) of certain developments will be addressed and explored with the aim to keep control over reliable and validated information for the state-of-the-art treatment processes we entrust our patients.

Distress Not Despair: Reducing the Emotional Burden of Medicine by Teaching About Countertransference During the Psychiatry Clerkship

Chair: Lionel Antonio Perez, M.D.

Presenter: Lindsay Lebin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the emotional challenges that medical students experience on their psychiatry clerkship; 2) Understand countertransference as a concept that can be taught during the psychiatry clerkship and that can be useful for students regardless of what field of medicine they eventually choose; 3) Develop teaching interventions using a three-task model consisting of helping students with intellectual understanding, experiential awareness, and

management of countertransference; and 4) Identify and manage potential challenges that may arise when teaching about countertransference

SUMMARY:

When medical students enter their clerkships, they begin developing professional identities and navigating the emotional landscape of caring for patients. With limited preparation for this during pre-clinical years, students can be overwhelmed and ill-equipped to face these challenges. Unrecognized feelings in the doctor-patient relationship can emerge when students are confronted with 'difficult patients', secondary trauma, or provider hopelessness. Unattended, this can affect clinical decision-making. While these concerns impact all specialties, they are especially prominent in psychiatry where students repeatedly encounter challenging patients and emotionally stressful situations. This offers an ideal opportunity to explore countertransference and ease the students' role transition. Managing countertransference is important for developing physicians as it is intertwined with larger issues of clinical judgment, professionalism, and burnout. However, teaching about countertransference presents unique challenges for the educator, and often it is left as part of the hidden curriculum. Students are thus at risk for missing valuable concepts in their growth as physicians. In this workshop, we'll explore the emotional burden faced by students in the psychiatry clerkship, based on personal experience and the literature. We'll work with participants to explore how to leverage the challenges the psychiatry clerkship presents to explicitly address countertransference. We will do this by introducing a three-task model of teaching countertransference consisting of helping students with intellectual understanding, experiential awareness, and management of countertransference. Using a sample case of a medical student, participants will break into small groups various times to discuss what the student is experiencing and how to help him identify, understand, and manage countertransference. We will watch a short video of a sample medical student interview to further generate discussion. Participants will leave having developed a variety of teaching interventions to help medical students learn about and manage these

emotions, as well as having discussed and worked through potential challenges to implementing these teaching interventions.

Effective CBT With Youth: Keeping the “Pro” in Procedures

Chair: Robert D. Friedberg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the core competencies necessary to deliver proficient CBT to young patients; 2) Gain skills in constructing parsimonious case conceptualizations; 3) Build proficiency through understanding the specific rubrics guiding innovative CBT interventions; 4) Obtain skills in measurement-based care; and 5) Learn to objectively evaluate CBT competencies through CBT rating scales

SUMMARY:

Cognitive behavioral therapy (CBT) approaches with youth are founded on sound empirical findings. Additionally, child psychiatrists and other mental health specialists increasingly report using CBT techniques. However, while laboratory findings in academic settings yield robust effect sizes, recent research reveals that in treatment-as-usual (TAU) settings, CBT is misapplied to various clinical populations and improperly implemented. Accordingly, there is a call to deliver CBT in a more effective manner in the community. This practical session is focused precisely on this aim. The session is designed to improve child psychiatrists' and other behavioral health clinicians' professional competence in delivering CBT techniques to young patients so they can become CBT PROs. In order to be a CBT PRO, several rudimentary benchmarks must be met. These competencies include case conceptualization, therapeutic stance (e.g. collaborative empiricism, guided discovery), adherence to session structure (e.g. mood check in, agenda setting, session content, homework assignment, eliciting feedback), clinical flexibility, proficient use of cognitive-behavioral techniques, and measurement-based care. Each of these competencies will be explained and ways of evaluating skillfulness via rating scales will be presented. Participants will learn to craft a

parsimonious yet robust case conceptualization that personalizes evidence-based treatment. Additionally, innovative procedures will be broken down into easy-to-follow basic rubrics and steps. Attendees will receive various worksheets and learn common exercises to apply with their young patients. Several recommendations for tracking outcomes in measurement-based care will be offered. Finally, a scale for rating CBT competencies will be reviewed and attendees will receive a copy of the measure along with a scoring manual. Further, this presentation is entirely consistent with the 2019 APA conference themes of revitalization, innovation, inclusiveness, and engagement. The goal of clinical revitalization is realized through a renewed and well-defined focus on case conceptualization. Innovation is served by presentation of inventive techniques and procedures to treat young patients. Inclusiveness and engagement are achieved by a profound appreciation of the contextual complexities surrounding young patients' clinical presentations. This practitioner friendly session provides clinicians with ready-to-use material based on state-of-the-science findings. Case examples will illustrate and enliven the relevant concepts. Attendees will take home detailed handouts and other resource material.

Enhancing Proactive, Patient-Centered, Team-Based Care Through Innovative Design

Chair: Steven Evans Lindley, M.D., Ph.D.

Presenters: Angela Denietolis, John Chardos

Discussant: Andrew S. Pomerantz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the advantages of proactive, patient centered, collaborative team based care.; 2) 2. Identify current barriers to team-based care and list possible counter-measures; and 3) 3. Recognize the importance of building design and models of care for continuous quality improvement.

SUMMARY:

Proactive, patient centered, team based, collaborative care is vital to optimizing health and well-being for the population as a whole. Collaborative delivery of primary and mental health

care engages patients at the point of service, identifies problems at earlier stages, decreases the stigma of seeking care, enhances access, improves efficiency, reduces costs, and yields better mental health and medical outcomes. Yet most of our traditional clinical workspaces and care delivery models were not designed with team-based, patient-centered, efficient care delivery in mind. Our current workspaces and practices also contribute to provider stress and burn-out. Advancing the quality of care, improving patient well-being, and provider satisfaction requires us to re-think our old ways of doing business. Our presenters include psychiatrists and internists with local and national leadership experience. Our session will first review the evidence for the advantages of collaborative, team based care. The presenters will guide the audience in an interactive process to identify current barriers to pro-active, integrated, patient-centered health care delivery and how these can contribute to provider burn-out. We will then described the physical design and models of care developed at two innovative clinical buildings designed to facilitate team-based care, reduce waste and improve efficiencies. We will review some of the positive and negative experiences of clinicians working in and patients treated in those facilities and elicit audience responses to the design. We will conclude the session with an interactive, brainstorming session with the audience on possible future solutions to optimize health care delivery while improving provider experiences and satisfaction.

Every Interaction Is an Opportunity: Training Residents to Use Psychotherapy in Contemporary Clinical Practice

Chair: Donna Marie Sudak, M.D.

Presenters: Alison Lenet, Erin M. Crocker, M.D., Randon Scott Welton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the challenges faced by psychiatry residencies in providing psychotherapy training; 2) Discuss the opportunities to promote psychotherapy outside of the traditional therapy clinic; 3) Appraise the value of standardized evaluations in psychotherapy training; and 4) Explain

different methods to develop faculty members' skill in providing psychotherapy supervision

SUMMARY:

The opportunity to employ psychotherapy in all clinical interactions is a powerful tool for change available to all psychiatrists. The recognition of the importance of this skill set has resulted in the development of new and innovative ways to teach psychotherapy throughout the course of psychiatry residency. Inpatient units, Consultation-Liaison services, psychiatric emergency rooms, and integrated care settings are all excellent locations for psychotherapeutic treatment and training. This symposium will explore the opportunities and challenges of teaching psychotherapy across the residency continuum, offering presentations about innovations in psychotherapy training and faculty development and highlighting the work of AADPRT in this area.

Finding a Better Rosetta Stone to Translate Research Into Practice: Innovative Ideas for Dissemination and Training

Chair: Robert D. Friedberg, Ph.D.

Presenters: Sara Becker, Ph.D., Allen Miller, Ph.D., Rebecca Friedberg, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn 3-4 ways to engage practitioners in dissemination and implementation efforts; 2) Recognize 3-5 problems with existing knowledge distribution channels; 3) Discover 3-5 new and underutilized dissemination outlets; 4) Acquire 3-5 ideas for dissemination based on business-to-business and direct-to-consumer marketing principles; and 5) Appreciate the ways behavioral rehearsal, consultation, and trainers' attributes potentiate workshop effectiveness

SUMMARY:

Translating basic science to office practice is essential to providing state-of-the-science evidence based procedures to distressed patients. Fortunately, many contemporary psychosocial interventions enjoy considerable empirical support. However, these evidence-based methods are often ineffectively delivered in treatment-as-usual

community settings. Thus, the knowledge yielded by strong science rests inertly in scholarly journals, textbooks, and manuals. Consequently, the research-practice gap endures. Accordingly, finding a better Rosetta Stone that translates lab results to practicing clinicians in an accessible and portable manner is pivotal. The expert panel (Drs. Friedberg, Becker, Miller and Ms. Friedberg) focuses on this complex translational task by addressing several superordinate themes. First, clinicians are often seen as merely end-users of evidence-based practices rather than as co-developers and partners. Therefore, they become passive recipients and may lack ownership in the process. Several inventive ways to engage and include practitioners in dissemination and implementation efforts will be discussed. Second, the traditional dissemination channels such as scholarly journals, texts, manuals, and workshops do not reach many working clinicians. Therefore, more information platforms are needed. Panelists will discuss problems with conventional distribution channels and offer recommendations for other outlets. Third, practitioners and patients should be viewed as potential consumers of evidence-based practices. Accordingly, the idea of applying business-to-business and direct-to-consumer marketing principles to the research-practice gap problem will be presented. Fourth, workshops are a common method for communicating evidence-based procedures, but their effectiveness in changing clinicians' practice patterns is frequently attenuated. The panel tackles this thorny problem and will offer specific recommendations such as maximizing trainer effectiveness, optimizing attendee engagement, fostering behavioral rehearsal, and providing on-going consultation to improve workshop training. This panel proposal precisely aligns with 2019 convention's themes of disruption, innovation, revitalization, inclusiveness, and engagement. The proposal serves disruption and innovation by challenging the existing knowledge distribution channels and suggesting creative alternatives. Efforts at shrinking the long-standing research-practice chasm are revitalized by presenting new methods and processes. Finally, inclusiveness and engagement are realized by emphasizing clinicians' roles as active partners in the translational process.

Finding Your Match: The Process of Obtaining Residency Positions

Chairs: Muhammad Zeshan, M.D., Panagiota Korenis, M.D.

Presenters: Ahmad Hameed, M.D., Mujeeb Uddin Shad, M.D., M.S., Michelle P. Durham, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss common pitfalls in application, personal statement, and during interview.; 2) Provide tips how to communicate with the program coordinator, program director, faculty, and residents during the interview day.; 3) Discuss how to address some potential "red flags" like professional gaps or USMLE attempts.; and 4) Provide some strategies to submit rank order list.

SUMMARY:

Applying to a residency or fellowship program is often a daunting process, which involves a complicated set of strategies and decisions. Unfamiliarity with the system and misunderstandings about what is expected from applicants can lead to frustration, stress, and avoidable mistakes. According to the Electronic Residency Applicant Service (ERAS) data, the number of psychiatry positions has grown every year since 2008, and the 1,556 positions offered in 2018 was the highest record. Out of 1,540 total filled positions, 982 were filled by U.S. Seniors and 264 by foreign-trained physicians. The number of U.S. Seniors matching to psychiatry residency have increased consistently over the past five years (5.5%). In contrast, a smaller proportion of International Medical Graduates (IMG) matched (6.1% in 2014 to 3.8% in 2018). As per the National Resident Matching Program (NRMP) survey results 2017, program directors (PD) consider the following top five factors for selecting an applicant to interview: Dean's Letter or MSPE (92%), personal statement (95%), letters of recommendation in the given specialty (90%), perceived commitment to the specialty (89%), and USMLE Step 1 and Step 2 scores (81%). PDs rank applicants based on their interpersonal skills (96%), interactions with faculty during one's interview and visit (94%), feedback from current residents (87%), and perceived

commitment to specialty (86%). In turn, residency applicants are noted to make rank order lists based on following top five factors: overall goodness of fit, interview day experience, geographical locations, quality of residents in the program, and work/life balance. During residency, important factors in assessing residents' success consist of clinical competency, quality of patient care, professionalism, ethics, and communication skills. While in training, it is important for a resident to identify any affinity for a subspecialty, which can help guide the path towards pursuing a fellowship. The main goal of this workshop is to add insight about the residency match, and help applicants improve their chances of getting into their desired programs.

French and U.S. Innovations in Cognitive Remediation

Chairs: Francois C. Petitjean, M.D., John A. Talbott, M.D.

Presenters: Isabelle Reine Amado, Caroline Demily, Kim Mueser

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about cognitive remediation for patients with severe mental illness; 2) Learn about a cognitive remediation tool for children with developmental disorder; and 3) Learn about cognitive remediation and exercise for individuals with severe mental illness

SUMMARY:

Rehabilitation interventions for patients with severe mental illness (SMI) aim at improving functional outcomes and promoting recovery. Recovery is a multidimensional concept but there is a consensus on considering two areas in its definition: clinical remission and social functioning. Cognitive deficits appear as a strong predictor of poor social functioning in schizophrenia. Among the different evidence-based psychosocial interventions, cognitive remediation is a behavioral training-based intervention that aims to improve cognitive processes (attention, memory, executive function, social cognition or meta cognition) with the goals of durability and generalization (Cognitive remediation experts working group, 2012). Two meta-analysis, one by T Wykes (2011) and one by S McGurk (2007)

have shown that it benefits patients with schizophrenia, the benefit extending to functioning when combined with other rehabilitation approaches. Cognitive remediation (CR) thus appears as a promising field of research and innovation to bring significant improvement for individuals with SMI. CR has also been developed for children, notably for neurodevelopmental disorders. In this session, innovative approaches to CR will be presented. Isabelle Amado from Paris, France will present a new tool using virtual reality in cognitive remediation. Caroline Demily from Lyon, France will talk about a new CR tool for children with neurodevelopmental disorders, and Kim Mueser will show how physical exercise can be combined with cognitive remediation for patients with severe mental illness.

French and U.S. Innovations in Vocational Rehabilitation

Chairs: Francois C. Petitjean, M.D., John A. Talbott, M.D.

Presenters: Nicolas Franck, Susan McGurk, Gary Bond

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about individual placement and support, an evidence based model; 2) Learn about cognitive enhancement and supported employment in severe mental illness; and 3) Learn about supported employment as part of psychosocial rehabilitation programs

SUMMARY:

Rehabilitation interventions have been developed to promote recovery and improve functional outcomes. New perspectives on the concept of recovery from schizophrenia and other severe mental illnesses (SMI) have renewed hope and challenged treatment providers to adopt a more optimistic attitude and collaborative approach in their work with consumers. Recovery goes far beyond symptom remission as the person's level of functioning is relatively independent of the actual symptoms. Functional outcomes are more affected by neurocognition. Work is valued by consumers and other stakeholders as it connotes contribution to society. Making a contribution to society and promoting citizenship as a result of a work role can

improve recovery. Without a work role an individual will have limited income, routines and choices and experience social isolation, which are all recognised as stressors. In the field of rehabilitation, cognitive remediation appears as key to allow better functioning in the social environment and at work for individuals with severe mental illness. Improving cognition in people with SMI produces consistent gains in a variety of cognitive domains. Recent efforts have focused on combining cognitive remediation with vocational rehabilitation in order to improve work functioning. In this session Susan McGurk from Boston University will speak on cognitive enhancement and supported employment, and Gary Bond, from Westat, Rockville, Maryland will present an evidence based employment model. Nicolas Franck, From Lyon University, France will show how a cognitive remediation network has been developed in France, allowing for the implementation of rehabilitation techniques throughout the country, thus providing mental health teams with adequate tools to promote recovery in individuals with SMI.

Frontiers in Advocacy: Creative Ways to Lead Meaningful Change in Psychiatry

Chairs: Luming Li, M.D., Mary C. Vance, M.D.

Presenters: Katherine Gershman Kennedy, M.D., Ilse R. Wiechers, M.D., M.H.S., M.P.P., Julie A. Chilton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discover creative ways to advocate for patients and the psychiatric profession, through routes other than legislative action; 2) Discuss the creation of change through different domains of advocacy, including the use of educational tools, data-driven advocacy, public storytelling, book writing, and organizational advocacy; 3) Understand the impact of advocacy on psychiatrists' personal and professional lives, as well as its impact on patients and the mental health care system; and 4) Practice advocacy skills by creating an advocacy

SUMMARY:

Advocacy, in healthcare settings, is the public voicing of support for causes that can positively impact

clinical practice and healthcare policy. For today's psychiatrists, the ability to advocate is vitally important, especially as our patients and organizations are struggling to survive in an increasingly expensive and inefficient healthcare practice environment. In mental health, advocacy has been focused primarily on legislative action. However, there are many ways to advocate, and meaningful change can come from using other creative methods as well. In this session, we will share the individual stories of advocacy leaders who have used creative methods to create impactful results, and teach these methods to our listeners with an interactive approach. The speakers will describe examples of successful advocacy efforts that utilized teaching methods, data science, and communication tools within various practice settings. The methods we will describe allow for powerful engagement and alignment of stakeholder groups, and work to drive change through persuasion, negotiation, and influence. Throughout the session, the speakers will emphasize focused learning points and specific skills for creative advocacy in psychiatry. To open the session, we will describe five creative advocacy domains, which include education, organizational advocacy, data-driven advocacy, book writing, and public storytelling, and share individual stories of advocacy leadership in these areas. Specifically, we will describe the development of an educational program in a large academic center to teach and engage young physicians to be leaders and stronger advocates. We will also describe local administrative advocacy in a complex healthcare organization, and share an example of leveraging interpersonal relationships and new governance structures to acquire additional resources and promote safe, patient-centered clinical care. We will share the story of a psychiatrist who leveraged data from a national electronic health records system to drive program development and policy changes aimed at improving prescribing practices for vulnerable patient populations across an integrated healthcare system. We will then describe the creation of a deliverable academic "product" for advocacy, in this case in the form of a handbook publication on mental health advocacy. Finally, we will share a psychiatrist's experience with using self-disclosure as advocacy, and how important wellness mentorship is

to normalize self-care for medical students and trainees. The session will provide an opportunity for audience members to participate in an interactive activity, in which they will break out into small groups and be asked to come up with a challenging problem related to mental health care delivery that can benefit from a creative advocacy approach. The groups will then be asked to problem-solve and create a deliverable advocacy solution that will be shared with the full audience.

Grabbing the Third Rail: Race and Racism in Clinical Documentation

Chair: Matthew N. Goldenberg, M.D., M.Sc.

Presenters: J. Corey Andrew Williams, M.D., M.A., Natalie Lastra, M.D., Nkemka Esiobu, M.D., M.P.H., Jessica Elizabeth Isom, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe two reasons why race is prominently mentioned in clinical medicine and two reasons why such prominence may be problematic.; 2) Understand race as a social construct as opposed to a biological reality.; 3) Explain health disparities as a function of racism as opposed to race.; 4) Demonstrate how to inquire about a patient's experience of race and racism.; and 5) Appreciate the social history and cultural formulation interview as places for discussion of a patient's experience of race and racism.

SUMMARY:

"A 24yo Caucasian male with a 2-week history of worsening mood", "A 72yo African-American woman with a history of diabetes brought in by her daughter for increased forgetfulness", "On exam, an age-appearing Asian woman in no acute physical distress." Phrases that bring attention to a patient's race are common in clinical medicine including psychiatry. Participants will be challenged to consider various important questions: Why do we include race so prominently in our case documentation, and what are the implications of such conspicuous placement? Does race matter in clinical medicine and, if so, how and when? How do we elicit information about race? Do we include race in all patient formulations or only certain ones and how do we decide? In this interactive session, we

will engage participants in an active discussion of race and racism using straw polls and case examples. We will present data on race as a social as opposed to biological construct and discuss racism, as opposed to race itself, as the source of racial health disparities. Participants will practice asking patients about their racial (and other) identity and its relevance to their lives. We will discuss the value of including race as a patient-informed contribution to the CFI (cultural formulation interview).

Gun Violence Is a Serious Public Health Problem Among America's Adolescents and Emerging Adults: What Should Psychiatrists Know and Do About It?

Chair: Stephan M. Carlson, M.D.

Presenters: William Connor Darby, M.D., Ziv E. Cohen, M.D., Jason E. Hershberger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the historical reasons why the CDC is restricted from studying gun violence.; 2) Describe the disproportionate percentage of young blacks who are gun homicide victims.; 3) Explain why providing trauma-informed care to youth who have experienced gun violence may reduce future gun carrying and gun violence among high risk, vulnerable adolescents.; 4) Describe the impact of increased firearm access and right to carry laws on college campuses on liability concerns for students with a history of mental illness.; and 5) Describe the rates of diagnosed mental illness among those who commit gun violence.

SUMMARY:

This symposium will provide a public health framework to underscore why gun violence exposure is a serious health risk for adolescents and emerging adults. The reconciliation and alignment of a public health framework, with existing social and attitudinal beliefs about firearms, to reduce youth exposure to gun-related violence will be discussed including gun safety and reducing access to lethal means. Gun violence—whether in the form of homicides, mass shootings or suicides, kills nearly 30,000 Americans every year. These daunting statistics have not motivated Congress to allow for more federal funding to understand this public

health problem. The goal of this session is to inform mental health clinicians about firearm-related violence and its impact on the mental health of adolescents and emerging adults. Repeatedly the USA has suffered the trauma of mass shootings. All people develop optimally in safe, stable, stimulating, and nurturing relationships. Children's brains and bodies develop, in part, from experiences, and violence can leave its mark on the body, brain and even the DNA. Stress impacts health at all ages and has a major effect on when and if adults experience disease and death. More than half of all adults have experienced adverse childhood experiences, potentially reducing their health, well-being and overall success in life. Unless the root causes of violence are effectively addressed, the symptoms will surface in one form or another when, in many cases, they could have been prevented. Gun violence is often associated with people who have experienced toxic stressors in childhood, which can disrupt the normal developmental trajectory of children. Traumatized individuals who may be at increased risk to commit acts of gun violence do not always display psychiatric disorders that would bring them to the attention of authorities or mental health care systems. They more often commit other acts of violence like domestic violence or community violence.

Hands-on With Smartphone Apps for Serious Mental Illness: An Interactive Tutorial for Selecting, Downloading, Discussing, and Engaging With Apps

Chair: John Torous, M.D.

Presenters: Arthi Kumaravel, Keris Jän Myrick, M.B.A., M.S., Liza Hoffman, L.I.C.S.W., M.S.W., Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn how to select safe and effective smartphone apps for caring for patients with SMI; 2) Download, load, and use at least three smartphone apps for SMI during the session; 3) Formulate how apps fit into the treatment plan and understand best practices for use in SMI; and 4) List at least three risks in using apps in care and the three strategies to mitigate those risks

SUMMARY:

Increasingly, patients with SMI are interested in smartphone apps for mental health and seeking guidance about the use of these apps from clinicians. This session will help clinicians become more familiar with using apps for SMI and assumes no familiarity or background knowledge with smartphone or apps. This interactive and step by step guided session will provide hands on learning and skills that clinicians can use to help them make more informed decisions about apps for SMI, download and install apps onto smartphones, and formulate treatments plans that ensure ethical, safe, legal, and effective use of these new digital tools.

Have Your Cake and Eat It Too: Institutional Approaches to Managing Patients With Anorexia Nervosa

Chair: Sara S. Nash, M.D.

Presenters: Evelyn Attia, M.D., Laurel Mayer, M.D., Maalobeeka Gangopadhyay, M.D., Matthew Shear, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the unique challenges to treating patients with anorexia nervosa on a consultation-liaison service; 2) Learn specific organizing and team-building techniques for managing patients with anorexia nervosa in a medical setting; 3) Understand how illness symptoms, including maladaptive coping mechanisms utilized by patients and families, can affect treatment care teams; 4) Understand how different institutional approaches can minimize the disruptive effect of some patient behaviors; and 5) Explain the institutional approaches on a specialized eating disorders unit that lead to optimal success for patients with anorexia nervosa

SUMMARY:

Due to the extensive physical as well as psychiatric morbidity and mortality associated with anorexia nervosa (AN), patients with this illness may require medical hospitalization for stabilization prior to admission to specialized eating disorders units. Dr. Nash will present the case of a 21 year-old woman with severe AN (nadir BMI 9 kg/m²) whose complex, month-long medical admission included the management of dehydration, electrolyte

disturbances, and re-feeding syndrome in the general medical ward and ICU settings. She will discuss the role of the consultation-liaison psychiatrist in the medical and psychiatric care of the AN patient, as well as the logistical, ethical, and legal issues involved in feeding over objection. In addition, Dr. Nash will discuss how the patient's personality traits and behaviors initially inspired empathy and a minimization of presenting pathology, but later led to disagreements among clinical staff and anger towards the patient from her physicians, nurses, nutritionists, and hospital support personnel. Dr. Gangopadhyay will offer a comparison with a more structured treatment model for patients admitted for disordered eating, including AN, that she and her colleagues established on a Child C-L service, and will explore the multidisciplinary team-based protocol used for patients with AN on inpatient pediatrics units. Drs. Attia and Mayer will discuss the highly programmatic and interdisciplinary approach to treatment implemented on a specialized eating disorders unit. Dr. Shear will discuss the treatment received by this patient on such a specialized unit following her medical hospital stay. Following this panel discussion, there will be an opportunity for active engagement of the audience in a question-and-answer discussion period.

How Psychiatrists Can Utilize a Public Health Approach to Address Human Trafficking

*Chairs: Rachel Robitz, M.D., Mollie R. Gordon, M.D.
Presenters: Mariam Garuba, M.D., Kenneth S. Chuang, M.D., Shaylin P. Chock, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the scope and epidemiology of human trafficking; 2) Discuss tools that a psychiatrist could use to identify a trafficked individual in various clinical settings; 3) Compare different strategies for addressing the unique behavioral health needs of trafficked individuals in community-based, hospital-based, and pediatric settings; and 4) Describe 1-2 creative ways in which psychiatrists can collaborate with other disciplines to care for the complex needs of trafficked individuals

SUMMARY:

The International Labor Organization estimates that globally there are roughly 40 million trafficked individuals; there are an estimated 5.4 trafficked individuals per thousand people in the world and a quarter of them are children (ILO, 2017). While the estimates of the prevalence of trafficking is high, only 66,520 victims were identified in 2016 (US Dept of State, 2017). Human trafficking is widespread, yet due to its underground nature, trafficked individuals are grossly under-identified. Trafficked individuals who have been identified commonly experience mental illness, and in one study, roughly 40% of women trafficked for sex have a history of attempting suicide (Lederer, 2016; Oram, 2012). While human trafficking has traditionally been addressed as a criminal justice issue, there is a growing movement to address human trafficking as a public health issue. This approach allows diverse stakeholders, including mental health professionals, to come together to both prevent trafficking and address the myriad of health consequences experienced by trafficked individuals (US Dept of State, 2017). While, in the United States, the 67-88% of trafficked individuals seek medical care, providers are often unaware that they are treating trafficked individuals (Lederer, 2014; Chisolm-Straker, 2016). Recently, there has been an increase in the number of educational programs about human trafficking for healthcare providers, but traditionally training on how to identify and treat survivors of human trafficking is not a standard part of psychiatric education (Coverdale, 2016; Powell, 2017). This workshop will provide an overview of human trafficking including its scope and epidemiology. It will provide an introduction to identifying trafficked individuals in psychiatric settings including potential red flags, common presentations, and considerations that should be taken when developing protocols for identification. The session will then discuss approaches to caring for the complex and unique mental health needs of trafficked adult and children. Speakers who provide inpatient and outpatient care in both hospital-based and community-based settings will discuss innovative approaches to treatment. Session participants will also have the opportunity to consider how to optimally address the mental health needs of trafficked individuals in their own work settings.

Improving the Culture of Care With NAMI: Understanding the First Person and Family Experience Makes a Difference

Chair: Kenneth S. Duckworth, M.D.

Presenters: Jacqueline M. Feldman, M.D., Teri S. Brister, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Understand the role of stigma in providing effective health care services; 2) 2. Understand the importance of fully engaging the patient and the family in each aspect of the treatment process; 3) 3. Understand the stages of response to having mental illness in your life from the perspective of the patient and the family; 4) 4. Learn strategies for meeting the patient and family “where they are” in those stages of response; and 5) 5. Identify the barriers to a collaborative approach to clinical care for people with mental illness

SUMMARY:

Mental illness touches almost everyone’s life in some way causing feelings of isolation that deter people from seeking treatment. Stigma is also present in treatment settings among the people charged with providing care. Personal impressions of mental illness can impact the type of care patients receive and the level of interactions professionals have with patient and family. Stigma, often based in a lack of understanding of the day-to-day experience of having mental illness, is a barrier to the goal of collaborative care, including patient, family and health care professionals as partners in treatment. NAMI, the National Alliance on Mental Illness, is the nation’s largest grassroots mental health organization, bringing the voice of patients and families to policymakers, researchers and treatment providers nationwide. In 2018 NAMI partnered with Des Moines University (DMU), the nation’s leading producer of primary care physicians, to help change the effects of stigma by launching innovative programming focused on helping health care providers across specialties increase their comfort with discussing and treating mental illness. Such programs expose participants to the inside experience of being diagnosed with a mental illness, and how collaborative, empathetic care can be

implemented to improve patient outcomes. The NAMI DMU collaboration brought the NAMI Provider Program to third-year osteopathic medical students at DMU. Also used at the Houston Menninger Clinic, the program entails 15 hours of didactic and experiential learning. Designed to transform the ways psychiatric care is delivered by increasing comfort level and compassion in working with people with mental illness, it fosters clinical empathy for patients and families, and counters stigma. Research is being conducted on the effectiveness of the training and its outcomes. This novel approach of training physicians across specialties, particularly those going into primary care, is expected to have a profound impact on the students and the people they will serve and medical schools across the country. This session will provide an overview of the stages of reaction to having a mental illness from the perspective of patient and family. It includes case studies of how the person’s response to the treatment team varies based on those stages. The presenters will share strategies for communicating more effectively with patient and family based on this awareness which leads to a higher level of engagement in treatment. The presenters include two board certified community psychiatrists with diverse training backgrounds and work history, each having experience with NAMI and the collaborative approach to treatment. The third presenter is a licensed professional counselor with a work history in community mental health centers and is currently a director at NAMI. They are part of NAMI’s team working with the APA to develop the SAMHSA funded Clinical Support System for SMI center of excellence.

Increasing Access to Mental Health Care in Low- and Middle-Income Countries: Examples and Strategies From Sub-Saharan Africa

Chairs: Theddeus I. Iheanacho, M.D., Charles Dike, MB.Ch.B., M.P.H.

*Presenters: Jibril Abdulmalik, Emeka Nwefoh
Discussant: Sosunmolu O. Shoyinka, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review successful implementation projects aimed at increasing access to mental health care in Nigeria, Cameroon, Sierra

Leone, Niger, Burkina Faso, Cote d'Ivoire, Liberia, Guinea Bissau and Ghana.; 2) Participants will list lessons learned, transferrable skills and practice applications from these projects; 3) Participants will identify gaps in mental health care in their practice setting/institutions/countries; and 4) Participants will identify what role they, their institution or networks can play in adapting or tailoring these implementation projects to their local settings.

SUMMARY:

Over 80% to 90% of people with severe mental disorders in low- and middle-income countries (LMICs) receive no treatment. Access to minimally adequate treatment for people with depression in LMICs is 4%. Treatment gap for other mental disorders are equally dismal. Most sub-Saharan countries are particularly affected due to inadequacies in general healthcare infrastructure. The consequences of this gap include: symptom persistence and deterioration, social exclusion, and long-term disability of people who could be economically and socially productive. Such low treatment rates in LMICs are related both to limited supply of mental health specialist care and limited demand for mental health services. On the supply side, mental health specialists are few, and largely hospital-based in major cities. In primary health care (PHC), general medical settings and gynecology services, most staff receive little training on the identification and treatment of people with mental illness. Demand-side barriers include low rates of help-seeking because of negative attitudes among the population. A global effort therefore is required to increase access to care and to diminish the impact of mental disorders in terms of burden of disease, premature mortality, morbidity, and stigma and discrimination. In this APA session, three presenters will share examples of their projects implemented in LMICs in sub-Saharan Africa geared towards increasing access to mental health care for underserved populations. These projects span nine LMICs countries Africa (Nigeria, Cameroun, Sierra Leone, Niger, Burkina Faso, Cote d'Ivoire, Liberia, Guinea Bissau and Ghana) and involve collaboration between in-country specialists and those in diaspora, use of mobile technology, and utilization of lay health workers. They also include policy advocacy work with government health departments, service

user empowerment through projects supporting development of self-help groups and integrating mental health treatment into established programs for other diseases. A section will explore the mental health impact of domestic terrorism on displaced and vulnerable populations and strategies for addressing the mental health needs of these populations. The presenters will describe facilitators and barriers encountered during their projects, implementation process, lessons learned and opportunities for improvement. Using Nominal Group Technique (NGT) participants in this session will list areas of mental health care gap in their practice and identify potential opportunities to adapt the presented projects or aspects thereof to their local settings. Participants will be encouraged to discuss in small groups to describe their backgrounds and identify possible mentors/collaborators to explore similar implementation projects. The speakers in this session will include two psychiatrists from Nigeria involved in projects across East and West Africa and their collaborating psychiatrists from the United States.

Innovative Approaches to Engaging and Advising Tomorrow's Psychiatrists

Chair: John J. Spollen, M.D.

Presenters: Jessica Graham Kovach, M.D., Mark Edward Servis, M.D., Robert Osterman Cotes, M.D., Shambhavi Chandraiah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Create an intervention that may improve recruitment of desirable candidates into psychiatry; 2) Understand the impact of the recent dramatic changes in the number of US medical students choosing psychiatry and the increased unmatched rate for those students; and 3) Develop strategies for evidence-based advising for medical students applying to psychiatry with impeccable, imperfect and intermediate applications

SUMMARY:

Recruitment of psychiatrists in-training is critical to the future of psychiatry. Knowledge of when and why medical students choose psychiatry can guide the development of innovative approaches, both

before and during medical school, to encourage the best and brightest to become tomorrow's psychiatrists. Data on who, when and why students choose psychiatry will be presented and participants will work in small groups to create initiatives to engage and encourage potential future psychiatrists needed for a large and diverse workforce. Complicating these efforts in recruitment, the residency match has become more complex and competitive in recent years which has created anxiety and confusion for both students and their advisors. Recent trends in the National Residency Matching Program relevant to psychiatry including the number of applications, board scores, match rates and geography will be presented. Participants will then devise strategies for evidence-based advising for medical students applying to psychiatry with both impeccable and imperfect applications. The key stakeholders and target audience include medical student advisors, clerkship directors, residency training directors, medical school admissions and residency selection committee members and other interested educators. The presenters are academic psychiatrists at multiple levels within psychiatry medical education who bring experience in recruitment and advising from different perspectives.

Innovative Strategies to Address the Underutilization of Clozapine

Chair: Dan Cohen, M.D., Ph.D.

Presenters: Henry A. Nasrallah, M.D., Dan J. Siskind, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) National and international clozapine prescription trends; 2) Barriers for clozapine prescription; 3) Strategies to overcome clozapine underprescription; and 4) Technical innovations that help lower the threshold of clozapine monitoring

SUMMARY:

Clozapine underprescription is a long standing and international issue, that remains difficult to overcome. In this course we present the barriers, both patient and doctor related, that have been identified to play a role in delayed clozapine

initiation. The USA, the first world country with the lowest clozapine prescription rates, is exactly for this reason most in need of effective strategies to overcome this severe obstacle. A national US network of experts in all aspects of clozapine is envisaged to expand evidence-based use of clozapine aiming at both a reduction of delayed clozapine initiation and increasing clozapine prescription rates. Technological advances offer new opportunities to help to lower monitoring threshold in clozapine therapy. WBC-Diff is an analyzer for PoC leukocytes count plus leukocytes differentiation from a drop of capillary blood. Results are available within 10 minutes. Validation shows good reliability within the normal range: when PoC-results are normal, they really are normal. When abnormal, regular venapuncture is required. Dried Blood Spot, a technique in use for decades for the detection of inborn errors of metabolism in the newborns, has been validated for the measurement of clozapine blood levels. Peripheral sampling is the main advantage of this technique, as the actual measurement still takes place in the laboratory. In short: PoC care saves the time, that is currently spent by the patients, patients' social support system and mental health workers. It makes treatment more efficient and can contribute to improved quality of patients' lives.

Innovative Treatments of Persons With ID and Psychiatric/Behavioral Disorders? Point Versus Counterpoint

Chairs: Robert Joseph Pary, M.D., Janice L. Forster, M.D.

Presenters: Jeffrey I. Bennett, M.D., Dorcas O. Adaramola, M.D., Mark Jeffrey Hauser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. By the end of the presentation, the participant will be able to discuss the impact of the environment on the management of mental illness/IDD; 2) 2. By the end of the presentation, the participant will be able to discuss innovative technologies to assist in the treatment of persons with IDD and psychiatric/behavioral disorders; 3) 3. By the end of the presentation, the participant will be able to discuss whether aspects of psychotherapy is or is not innovative for persons

with IDD; and 4) 4. By the end of the presentation, the participant will be able to discuss what, if any innovative psychotropic treatment exists for persons with IDD and psychiatric disorders

SUMMARY:

Persons with intellectual disability are among the most medicated individuals in society. Unfortunately, for many persons this has not resulted optimal outcomes. There is a need for innovative care. What innovations have occurred during the past twenty years in treating persons with intellectual disability (I.D.) and psychiatric and/or behavioral disorders? Have design flaws in pharmacologic research in persons with I.D. impacted advances¹? Mental retardation is no longer an acceptable term; Intellectual developmental disorder is used worldwide² and DSM5 utilizes the term I.D. While the importance of replacing the term, "mental retardation" cannot be overestimated, have there been significant innovations in treatment? Is telepsychiatry truly innovative for the treatment of psychiatric disorders in persons with ID, when Menolascino and Osborne published an article on it nearly 50 years ago³? Is supportive psychotherapy limited to only persons with mild I.D. or can persons with moderate I.D. also benefit⁴? Will etiologic-based diagnoses of ID offer specific interventions based on more than a phenomenological psychiatric diagnosis? Nor should the environment be ignored. Spitz et al showed dramatic differences based on age of adoption in Romanian orphans⁵. The presentations and subsequent panel discussions will offer point/counterpoint arguments about innovations in the treatment of psychiatric/behavioral disorders in persons with I.D. Audience discussion/disagreement/debate is encouraged.

Integrated Care Coast to Coast: Comparing Populations, Models, Outcomes and Sustainability in NYC and Seattle by Integrated Care Fellows

Chairs: Sarah Ricketts, M.D., Anna Ratzliff, M.D., Ph.D.

Presenters: Varsha Narasimhan, M.D., Elizabeth L. Chapman, Jessica Whitfield, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop an understanding of factors that influence variation in models of collaborative care, including population characteristics, diagnoses treated, existing infrastructure, and financing.; 2) Identify core components of collaborative care interventions and understand their rationale and impact on outcomes; 3) Consider the ramifications of the spread of integrated care for psychiatry residency training and the practice skills developed in integrated care fellowships.; and 4) Discuss collaborative care models compared to usual psychiatric care

SUMMARY:

In the context of a high incidence of psychiatric disorders, a national inpatient bed shortage, and a dearth of outpatient providers, effective, early behavioral health treatment has become increasingly important in the US. In multiple clinical trials, psychiatric integrated care in medical settings has been shown to be equal or superior to traditional psychiatric care in process and clinical outcomes. As a result, many health systems are adopting integrated care as they pursue quality patient care, improved population health, and decreased health care cost. Integrated care interventions share core components, including universal screening, nonphysician care managers, and specialist-provided stepped-care recommendations. However, they differ in implementation, reflecting the diversity of populations treated, differences in staff and infrastructure, and variations in financing. In our session, psychiatrists pursuing advanced training in integrated care will describe the structure, characteristics, successes, and challenges of their collaborative care programs, located across the United States. They will also discuss their experiences as trainees learning a developing model of care,

Interactions Between Neurobiological, Genetic and Environmental Factors of Vulnerability in the Development of Depression and Anxiety Disorders

Chair: Gustavo E. Tafet, M.D., Ph.D.

Presenters: Charles Barnet Nemeroff, M.D., Ph.D., Alan F. Schatzberg, M.D., Ned Henry Kalin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide updated scientific information to understand the interactions between neurobiological, genetic and environmental factors of vulnerability in the development of depression and anxiety disorders; 2) Understand the role of inflammatory processes in the development of depression and how these may affect treatment responses; 3) Understand the role of the HPA axis in the development of depression, focusing on different genes involved in cognitive functions and emotional processes; and 4) Understand the role of early adverse experiences in the development of neural changes involved in the origin of depression and anxiety disorders

SUMMARY:

The link between a history of stressful events and the origin and development of depression and anxiety disorders has been extensively studied, including the long-lasting effects of childhood traumatic events and the sustained impact of chronic stressful events during adulthood. In this regard, several studies suggest that depression and anxiety disorders may develop from the interactions between different neurobiological, genetic and environmental factors. Our session will address the molecular and biological mechanisms involved in these processes, including the effects of early adverse experiences in the neural circuitry underlying cognitive and emotional functions, the vulnerability represented by different genetic variations, the effects produced by endocrine alterations, focusing on the hyper-activation of the HPA axis and the resulting hypercortisolism, the effects produced by inflammatory processes in the CNS, and the effects produced by environmental factors in the regulation of these biological processes. We will provide updated information regarding the pathophysiology of these processes to share our current knowledge with the participants with the aim to better understand the reciprocal effects of these factors and therefore to develop more effective strategies for the treatment of depression and anxiety disorders. We will also discuss new scientific developments with new clinical approaches in psychiatry

Interactive Video Workshop: Improving Recognition and Management of Catatonia

Chair: Andrew J. Francis, M.D.

Presenter: Lex Denysenko, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this program, attendees will be able to identify three common signs of catatonia; 2) At the conclusion of this program, attendees will be able to identify two treatments for catatonia in medical or psychiatric patients; and 3) At the conclusion of this program, attendees will be able to identify two potential complications of prolonged untreated catatonia

SUMMARY:

While catatonia historically has been under-recognized in both psychiatric and medical settings, more recent clinical experience and research have led to a renewed interest. Of particular concern is detection and management of catatonia in medical settings and critical care units where catatonia may co-exist with delirium. These cases are often complex and require management by consultation-liaison psychiatrists. This program is designed to enhance the skills of psychiatrists managing these cases. Standardized instruments such as the Bush-Francis Catatonia Rating Scale [BFCRS] improve both recognition and monitoring of treatment. This scale comprises 23 items, and can be completed five minutes. The scale facilitates clinical diagnoses whether using DSM-5 criteria [3/12 catatonic signs] or Bush-Francis [2/14 signs]. Catatonia that is severe or persistent is accompanied by significant morbidity and potential mortality, so treatment is essential-- whether by ameliorating underlying medical and neurological illnesses or by targeted treatment with lorazepam, secondary medications, or ECT-- all of which have been useful in medical and psychiatric catatonia. Complications of severe or prolonged catatonia will be reviewed. These include neuroleptic malignant syndrome, aspiration, pneumonia, emboli, malnutrition, decubiti, and neuromuscular dysfunction. Examples of complications from catatonia will be shown in the video vignettes. Clinical vignettes and real-patient videos will be employed throughout this presentation to illustrate common and more rare

catatonic features, , and audience participation encouraged with lively ongoing audience engagement. This workshop will utilize a proven interactive format, designed to improve clinical skills in recognizing catatonia using the lead speaker's extensive video of psychiatric and medical patients before and after treatment. Explanatory comments from the workshop panelist will foster a discussion of management. Attendees will also gain experience using the Bush-Francis catatonia scale. Andrew Francis MD PhD FAPA [Professor of Psychiatry, Director of Neuromodulation Services, Penn State Medical School/Hershey Medical Center] is co-author of the Bush-Francis Catatonia Rating Scale and widely published in catatonia, neuroleptic malignant syndrome, ECT and delirium. He will present several apatient video vignettes of catatonia in an interactive audience-participation format [60 min including Q&A]. Lex Denysenko MD FACLP [Assistant Professor of Psychiatry, Kimmel School of Medicine at Jefferson University in Philadelphia] was the lead author of the 2015 Academy of Psychosomatic Medicine Monograph "Catatonia in Medically Ill Patients" and regularly gives presentations on catatonia at national meetings. He will provide commentary and discussion especially highlighting treatment aspects [15 min]. General audience discussion by Q&A is allotted 15 min.

Intersectionality 2.0: How the Film *Moonlight* Can Teach Us About Inclusion and Therapeutic Alliance in Minority LGBTQ Populations

Chairs: Amanda R. Wallace, M.D., Latoya Comer Frolov, M.D., M.P.H.

Presenters: Haining Yu, M.D., M.P.H., Keith A. Hermanstyne, M.D., Sean Arayasirikul, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define intersectionality and consider its relevance in regards to mental health issues in minority LGBTQ populations; 2) Apply concepts of intersectionality in relation to the life of a Black LGBTQ man as seen in the film "Moonlight"; and 3) Demonstrate understanding of ways in which intersectionality can manifest in the therapeutic alliance with minority LGBTQ populations

SUMMARY:

Intersectionality has historically been discussed in the context of black women's identities and their initial exclusion from the feminist movement. In this workshop, intersectionality will be defined and expanded to include perspectives from minority LGBTQ populations who often face multiple levels of discrimination. This will be illustrated by a brief viewing of clips from the movie *Moonlight* with short discussion to follow. Clips will highlight the ways in which sexual identity, notions of black masculinity, trauma and poverty intersect within the three phases of the main character, Chiron's life. The experience of Chiron will be extrapolated on to view intersectionality within the larger LGBTQ community, particularly risk and resilience. This information will be translated into clinical implications of intersectionality and patient caveats will be discussed focusing on the ways in which gender, race, ethnicity, and sexual orientation can affect the therapeutic alliance. In addition, medical sociologist Dr. Sean Arayasirikul will present his research on health disparities in transgender minority youth in San Francisco and consider the impact of intersectionality on discrimination and stigma.

It Takes a Village: Interdisciplinary Approaches to the Use of Clozapine in Patients With Persistent Psychosis

Chair: Alexander S. Young, M.D., M.H.S.

Presenters: Tristan Gorrindo, M.D., Amy N. Cohen, Ph.D., Donna Rolin, Ph.D., A.P.R.N., Teri S. Brister, Ph.D., Patrick R. Hendry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply measurement-based assessments in patients with psychosis; 2) Describe best practices for implementing clozapine in routine clinical care; and 3) Describe team-based staffing models for treating persistent psychosis

SUMMARY:

Persistent psychosis is common in individuals with schizophrenia and other chronic psychotic disorders, and results in substantial disability, homelessness, hospitalization, system utilization and

institutionalization. Through the use of measurement-based care and appropriate monitoring, interdisciplinary and team-based treatment of persistent psychosis can improve medication adherence and reduce medication induced side-effects. This session will use a series of clinical cases to examine treatment approaches, including the use of clozapine. While clozapine is more effective overall than other antipsychotic medications, it is more challenging to use, has a range of potential side effects and strict monitoring protocols. Inter-disciplinary strategies and care models for successful use of clozapine will be presented. Parameters for monitoring, required lab registry, and outcomes measures will be outlined. Prescribing and side effect management will be discussed.

Latino Undocumented Children and Families: Crisis at the Border and Beyond

Chair: Divya Chhabra, M.D.

Presenters: Caitlin Rose Costello, M.D., Tahia Haque, M.D., Andres Julio Pumariaga, M.D., Pamela Carolina Montano, M.D., Alma Valverde Campos, M.Ed.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand specific stressors faced during the immigration process: pre-migration, in-transit, and post-migration as well as the consequences of detainment and family separation.; 2) Demonstrate factors that contribute to the resilience of undocumented immigrants.; 3) Identify current legal policies around detainment, family separation, re-unification, DACA, and immigration that are relevant for mental health providers in a clinical setting.; 4) Discuss clinical case studies involving undocumented immigrant families and be able to demonstrate culturally, structurally, individually, and trauma-informed techniques.; and 5) Understand ways to become more involved with the undocumented immigrant population in terms of policy-making and advocacy.

SUMMARY:

The USA is home to 40 million immigrants and 35 million children whose parents are foreign born. Within this group, 11.4 million are undocumented immigrants, half of whom are of Latino origin.

Currently, there is an increasing focus on deterring undocumented immigrants with strategies such as increases in ICE raids, stringent refugee determination procedures, and increased confinement in detention centers. Specifically, the Zero Tolerance policy, which called for the prosecution of all individuals illegally entering the USA, resulted in the detainment and separation of thousands of families. News articles have compared the current situation to that of Japanese internment camps, which have had known long-term repercussions. As a human right, compassionate, competent, and trauma-informed mental health services should be provided when immigrants first arrive at the border. Undocumented children and adults undergo stressors across the various stages of the migration process: pre-migration (trauma in country of origin), in-transit trauma (including violence, trafficking, environmental hazards, abandonment) as well as trauma after migration (limited resources, intra- and interpersonal conflict, acculturative stress, limited resources, fear of deportation, and discrimination). As a result, undocumented immigrants have a higher risk of depression, PTSD, and substance use. Further research suggests that detention itself results in adverse mental health outcomes that worsen as length of detention increases. Serial migrators are at risk for maladaptive family functioning and depression, and consequences are both immediate and long-term. Forced removal and fear of deportation is linked to externalizing and internalizing problems among youth, low levels of family cohesion, and long-term behavioral changes. We must utilize research on resilience in this population to find ways to prevent the currently rampant and detrimental consequences. First, we will introduce participants to research that has been conducted on undocumented immigrants on risk factors, prevalence of mental illness, protective factors, and mental health treatments. Given the current political climate, we will have a brief section on detainment and family separation at the border. Second, we will hear from a forensic child psychiatrist about current policies regarding undocumented immigrants, DACA, as well as on family separation. Third, we will discuss two case studies that experts in the field have implemented with groups of undocumented immigrants, and we

will discuss via our panel what is currently being implemented at the border. In this section, we will divide into breakout groups and utilize roleplaying to come up with clinically relevant take home points. Lastly, we will hear the account of a DACA recipient and immigrant rights advocate. Information on ways to become involved both via clinical care as well as in advocacy/policy will be discussed.

Life Imitating Art? Fictional Depictions of Suicide, Copycat, and Contagion

Chair: Praveen R. Kambam, M.D.

Presenter: Vasilis K. Pozios, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide a basic summary of the research on effects of news and entertainment media on self-violence.; 2) Appreciate considerations in incorporating a patient's history of exposure to media violence into clinical applications.; and 3) Understand interventions psychiatrists can take to mitigate the potential risk posed by fictional media depictions of suicide.

SUMMARY:

Journalistic guidelines for more responsible suicide reporting reflect the belief that news media can influence suicide behaviors. However, similar guidelines for fictional depictions of suicide do not exist. But should they? Although the evidence linking fictional depictions to real-life suicide behavior is less studied than the effect of news reporting on suicide, should psychiatrists have similar concerns about fictional depictions? This workshop will offer an overview of the effects of news and entertainment media on self-violence. An up-to-date summary of the research on imitative suicide and media violence will be presented. We will argue why fictional depictions of self-violence may, theoretically, have similar or even greater impacts on behavior than news media. What considerations should be made in determining who may be more or less vulnerable to negative media effects? Should a targeted fictional media history be incorporated into psychiatrists' suicide risk assessments? Lastly, the workshop will suggest steps psychiatrists can take to mitigate the potential risk posed by fictional media depictions of

suicide, including educating parents and interfacing with entertainment and news media.

Managing Complex Co-Occurring Disorders Like an Addiction Expert: Applying Current Research and Treatment Resources

Chair: Ray C. Hsiao, M.D.

Presenters: Jeremy Douglas Kidd, M.D., M.P.H., Sandra M. DeJong, M.D., Kelly M. Blankenship, D.O., Andrew John Saxon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize common presentations of complex Co-Occurring Disorders (COD) in psychiatric practices; 2) Understand Medication-Assisted Treatment options for Substance Use Disorders and their application in COD patients; and 3) Identify ways of combining psychopharmacological and psychosocial interventions to achieve optimal treatment outcome for COD patients

SUMMARY:

With the rise of marijuana legalization and the current opioid epidemic plaguing the United States, more and more psychiatrists are encountering patients with complex co-occurring disorders in their practices. However, many practitioners feel under-prepared to handle such challenging cases based on their residency/fellowship training and their sentiments were recently confirmed in a survey of psychiatry training directors conducted by the American Association of Directors of Psychiatry Residency Training (AADPRT). Therefore, in an effort to re-educate current practitioners and develop a workforce capable of meeting the needs of the growing number of COD patients, AADPRT has convened a Taskforce on Addictions consisted of experts from various psychiatric organizations including the American Psychiatric Association (APA), American Academy of Addiction Psychiatry (AAAP) and the American Academy of Child and Adolescent Psychiatry (AACAP). The Taskforce is in the process of developing various resources for training on co-occurring disorders and this proposed session is one of the model educational activities aimed at training general psychiatrists on management of common co-occurring disorders. During our session, we will

have participants divide into 5 small groups to conduct three case studies of common co-occurring disorders. Each small group will be facilitated by a member of the AADPRT Taskforce on Addictions, and participants will be given a series of prompts and questions to learn about various diagnostic and treatment challenges frequently encountered in treatment of patients with co-occurring disorders.

Medical Conditions Mimicking Psychiatric Disorders Versus Psychiatric Disorders Mimicking Medicine Conditions: Diagnostic and Treatment Challenges

Chair: Catherine C. Crone, M.D.

Presenters: Noha Abdel Gawad, Corina Freitas, M.D., M.B.A., M.Sc., Kiarash Yoosefi, M.D., Rushi Hasmukh Vyas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop greater awareness of the complicated overlap between between medical and psychiatric comorbidities; 2) Discern the underlying cause of a patient's clinical presentation, whether primarily medical or psychiatric; and 3) Manage the care of patients at the crossroads of medical and psychiatric presentations

SUMMARY:

During the course of residency training, significant efforts are made to instruct residents about the recognition and treatment of primary psychiatric disorders such as major depression, bipolar disorder, post-traumatic stress disorder, panic disorder, and schizophrenia. However, exposure to cases that initially appear to be primary psychiatric disorders but are actually due to underlying medical conditions is often lacking, despite their common occurrence. Infections, hypoxia, electrolyte imbalances, endocrine disorders, autoimmune disorders (e.g. lupus, sarcoidosis) neurologic conditions (e.g. epilepsy, multiple sclerosis, delirium/encephalopathy) and medications are just some of the causes of patient presentations that mimic primary psychiatric disorders. Awareness of these "mimics" is needed as patients may otherwise appear to have "treatment-resistant" psychiatric disorders or, of greater concern, actually worsen when given psychotropic medications. This is needed information for both trainee and general psychiatrist

alike. An additional area of clinical knowledge that would benefit both residents and general psychiatrists is the recognition and management of psychiatric disorders that mimic medical conditions. Limited exposure to consultation-liaison psychiatry during residency training may result in lack of experience with conversion disorders, somatization disorders, and factitious disorders. These are patient populations that are often responsible for excessive utilization of medical resources and healthcare dollars as well as being sources of mounting frustration and misunderstanding for medical colleagues. Requests for psychiatric involvement are not unusual, especially when medical work-ups are negative yet patients persist in their requests for medical/surgical intervention. The following workshop aims to provide residents, fellows, and general psychiatrists with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatoform disorders (medical mimics) in a case-based format with opportunities for questions and discussion with residents, fellows, and attending physicians with experience and/or expertise in consultation-liaison psychiatry patient populations.

Medication-Assisted Treatment and Behavioral Strategies to Treat Adolescents and Young Adults With Substance Use and Related Disorders

Chair: Hector Colon-Rivera, M.D.

Presenter: Srinivas Muvvala, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the risk factors that predispose adolescents and young adults to substance use disorders and the protective factors that lead to resilience.; 2) Learn and practice skills necessary to conduct a primary inquiry about substance use disorder and recognize substance abuse and addiction in adolescent patients.; and 3) Understand types of adolescent substance use disorder interventions, including recovery protective services, and medication assistant treatment.

SUMMARY:

The transition from childhood to adolescence and subsequently adulthood represents two unique developmental periods with significant changes in

social networks and interactions. Increasing attention has been given to the possible disruptions and expected changes of cognitive and psychosocial transitions during these periods. Adolescence and early adulthood are the peak times for initiation of substance use disorders (SUD), particularly tobacco, marijuana, prescription drugs, and alcohol. Studies report substance use amongst teens has increased as a direct correlate to exposure to media with suggestive cues surrounding illicit drugs. The healthcare provider's capacity to respond appropriately to substance use disorders in adolescents is limited at best. Adolescents are particularly vulnerable to the high risk for severe complications of illicit SUD which include overdose, death, suicide, HIV, and hepatitis C. Both medication-assisted treatment and evidence-based SUD counseling, are available but underused in this vulnerable population. Also, access to developmentally appropriate treatment strategies is restricted for adolescents and young adults making effective treatment out of reach for this group. This workshop will discuss the prevention, screening, evaluation, and referral to treatment of adolescents with or at risk for substance use disorders. Presenters will discuss the latest evidence-based data on the use of medication assistant treatment and other therapies for the treatment of SUD for opioids, alcohol, tobacco, and stimulants. Also, the workshop will address the emergent issues around the use of E-cigarettes among adolescents.

Mental Health Providers' Primer Regarding Terminology, Lessons, and Resources on Sexual Orientation and Gender Identity and Expression

Chair: Richard Randall Pleak, M.D.

Presenters: Muhammad Zeshan, M.D., Panagiota Korenis, M.D., Shervin Shadianloo, M.D., Gino Anthony Mortillaro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Educate healthcare providers about common terms, definitions, and healthcare challenges faced by the LGBTQ+ community; 2) Advise how to ask questions about sexual orientation and gender identity by using non-judgmental and gender-neutral language; 3) Provide tips on how to incorporate LGBTQ+ curriculum in the

residency didactic schedule; 4) Provide list of LGBTQ friendly resources for patient and families; and 5) Provide a list of LGBTQ+ friendly resources for patients and families

SUMMARY:

Transgender, queer, questioning, intersex, asexual, allies, two-spirits, and pansexual (LGBTQQIAA2SP, or LGBTQ+) community frequently suffers from discrimination and disparity in physical and mental health treatment. This discrimination may lead to greater mental health burden and poor treatment out come in this population. The providers need education about providing sensitive and caring care to these patients in a non-discriminatory fashion. There is a great variety in etiology and presentation of LGBTQ+ individuals' needs regarding mental and physical health services. While it is known that the LGBTQ+ community is particularly vulnerable to depression, anxiety disorders, suicide, substance use, sexually transmitted diseases, social isolation, and homelessness, few studies exist assessing how effective providers are in treating this unique population. Although updated national guidelines exist for the medical care of this minority population, awareness of those guidelines in training physicians is limited. Because of lack of adequate formal training for physicians regarding sensitive and caring approaches towards the LGBTQ+ community for their health needs and risk factors, clinicians - particularly residents - may find it challenging to provide appropriate care to LGBTQ+ people without making them isolated, rejected, or even felt discriminated against. During this workshop, the speakers will have an interactive interview with a standardized patient to demonstrate the interview skills to the audience. The participants will also be able to participate in interactive Q&A sessions as well. The goal of this workshop is to provide further education to physicians, with a focus on clinicians in training, in order to improve the quality of care provided to the LGBTQ+ community with the longitudinal goal being to decrease the mental health care disparities suffered by this minority group.

Mindfully Addressing the Opioid Epidemic: Is Pain a Sensation or a Thought?

Chair: Robert Barris, M.D.

Presenters: Robert Barris, M.D., Anup Padmakar Deshpande, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand mechanisms of chronic pain, available treatment options and its impact on opioid crisis; 2) Understand the concept of mindfulness, its origin, clinical introduction and current practice; 3) Recognize the application, efficacy and future of mindfulness techniques in chronic pain management; 4) Provide our personal experience of using mindfulness with patients and their comorbid pain in an acute inpatient service in community hospital; and 5) Demonstrate interactive sessions with audience of mindfulness techniques for pain management

SUMMARY:

There are more than 25 million US adults suffering from chronic pain. There are three main modalities to address pain: pharmacological, physical and psychological. Among pharmacological options opioids were mainstay of the treatment for chronic pain. And as Abraham Maslow popularly phrased “if all you have is a hammer, everything looks like a nail”, opioid medications prescribed abundantly and superfluously in recent decade that resulted in opioid crisis. Physical modalities often fall short in addressing the chronic pain. Pain is conscious awareness of body distress and is the result of complex interaction of sensory, affective and cognitive mechanisms. In chronic pain plastic changes occur in thalamus and sensory cortex called ‘central sensitization’ which results in amplified response to trigger and even response in the absence of triggering event. Furthermore studies showed structural evidence of diagnosis of pain can be misleading like findings of herniated disc, spinal stenosis in completely asymptomatic individuals. Mindfulness is observing and accepting each moment nonjudgmentally and without reactivity. In our community hospital we arrange weekly session of mindfulness practice for selected patients with chronic pain with great success. Participants are directed to pay attention to origin of pain and its perception in mind. They are directed to be fully open to any sensation arising and reject nothing. There are numerous studies showing that

mindfulness meditation training can be highly effective in reducing self-reports of both pain and pain-related behaviors in the majority of the patients referred to it for chronic pain. Efficacy of mindfulness practice showed by clinical evidences like increased activations in brain regions associated with affective and cognitive component of pain like orbitofrontal cortex in MRI studies. MBSR, Mindfulness based CBT can be promising, non-addictive, easily performed, economical and efficacious treatment option for chronic pain.

More Forms to Complete? Engaging With Patients, Disability Management, and the Employer: New Strategies to Assess and Develop Return to Work Plans

Chair: Paul Pendler, Psy.D.

Presenter: Robert Scott Benson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Increase competency translating information obtained in psychiatric evaluation into language used by disability management companies which look for more focused assessment; 2) Learn how to utilize the APA Foundation, Center for Workplace Mental Health, “Work Function Assessment Form” and how to obtain the necessary clinical information from it.; 3) Appreciate the capacity to work as part of one’s overall optimal functioning and distinguish psychosocial issues from true impairments and how to discuss the differences with patients.; and 4) Increase one’s competency to develop a work return focused treatment plan to present to patients, disability management companies, and employers. Learn to present information in cogent manner.

SUMMARY:

According to a 2012 Lancet article, depression ranks as the leading cause of disability worldwide, affecting upwards of over 350 million people. The financial burden of this condition can be seen in examining presenteeism and absenteeism and depression has been identified as one of highest “costs” of workplace absenteeism (Dewa, Trojanowski, Joosen, & Bonato, 2016). Psychiatrists continue to be confronted with providing accurate diagnostic information on their patients to various

disability management companies yet often there is no clear standard to judge a patient's request for time off work. The relationship between psychiatric illness and workplace disability is not well understood and often disability benefits providers appear to approach psychiatrist evaluations with skepticism and distrust (Gold, 2011). As a result, physicians can often wind up chasing their own tail providing more and more "clinical information" to companies in order to support their evaluation about the need for time off from work. Often patient encounters become in essence solely focused on completing the various forms seeking evidence of inability work vs. establishing a clear treatment path towards returning to work. The 2017 ACOEM position statement clearly places a value on the role of work and challenges physicians to have a more active role to help restore patients to be able to function in the workplace. In fact the primary "medicine" for patients unable to work due to psychiatric conditions should in fact be to return to the workplace sooner vs. later. Unfortunately, with psychiatric conditions, there is a greater need to appreciate the therapeutic relationship that suddenly expands to include the employer, and disability benefits organizations (Mischoulon, 2002). To determine when a patient is unable to work requires exploring their health in conjunction with work characteristics creating a sense of one's "work ability" (Muschalla, 2017). Further complicating this assessment requires physicians to translate this into the language of disability benefits providers. Working with the APA Foundation, Center for Workplace Mental Health, a "Work Function Assessment Checklist" has been created in the hopes of unifying the general common elements needed to provide evidence when a patient is unable to work. This tool has already been placed in the public domain and the workshop will focus on how to utilize this checklist with patients seeking time off from work. The workshop will highlight how to specifically obtain the key functional work limitation information that can be present (vs. solely describing a diagnosis with symptoms) in order to better advocate for patient when seeking time off from work. Finally we will address the sometimes dilemma of "psychosocial issues" that can be present yet are not truly the cause for inability to work and strategies to engage with patients to help

them understand the role of the physician in returning one to work.

Myths and Facts About Medical Clearance of Psychiatric Patients in the Emergency Department

Chair: Samidha Tripathi, M.D.

Presenters: Leslie Zun, M.D., Kimberly D. Nordstrom, M.D., J.D., Michael Wilson, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to 1) Recognize common controversies about medical clearance of the psychiatrically ill in the emergency room.; 2) Practice and review guidelines to approach requests for medical assessment of the psychiatrically ill, using simulated case vignettes.; and 3) Identify the benefits of utilizing a triage and protocol model for evidence-based medical assessments and appropriate laboratory testing for psychiatric patients in the emergency room.

SUMMARY:

An emergency room (ER) is often the first point of contact with a physician for patients with psychiatric illness. Patients can present with variable concerns such as coexisting medical and psychiatric illness, psychiatric condition exacerbated by medical illness or visa versa, and medical illness presenting as psychiatric condition or visa versa. Thus, ER physicians are routinely asked to "medically clear" psychiatric patients, before an appropriate aftercare (psychiatric admission, or transfer to psychiatric crisis center etc.) can be determined. However, there is a lack of agreement over what this process should entail. Psychiatrists may not want to do an assessment until all possible organic pathology has been excluded, but they might be uncertain about what they are really requesting when they ask for the patient to be "medically cleared." Similarly, ER physicians might not be familiar with the universal requirement of "medical clearance" prior to transfers. They may perform a less than ideal evaluation of the psychiatrically ill due to lack of comfort with these patients or due to patient's limited participation, or due to the need to prioritize for "sicker" patients. This often leads to a difference in opinion amongst the ER physician and the

consulting psychiatrist. Our session will introduce the participants to common case scenarios that lead to requests for medical clearance in the ER. Through case based simulations and audience participation, the session will address controversies over “medical clearance”, and challenges encountered while navigating the management of such cases. The speakers will also review guidelines for approaching these requests for “medical clearance” of psychiatric patients in the emergency room. Speakers for the session include emergency medicine physicians and emergency psychiatrists. The senior faculty members in this session offer decades of experience in both emergency medicine and emergency psychiatry, having published extensively on this and various other topics relevant to emergency psychiatry.

New Frontiers in College Mental Health

Chair: Ludmila B. De Faria, M.D.

Presenters: Alexandra Ackerman, M.D., Victor Hong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. To understand current trends in college mental health and its impact on the delivery of care; 2) 2. To explore the relationship between technology and mental health in college age population; 3) 3. To highlight the clinical and legal predicaments of the modern college psychiatrist; and 4) 4. To explore the impact of access to psychiatric care for academic success

SUMMARY:

The field of college mental health has changed significantly from its modest beginnings when its goal was to “help college students with personality development and building a healthy mind”. It now includes a variety of services and settings and involves collaborative work both in and outside the institutions. All of this has rapidly evolved in less than a century and it has not been without growing pains. The widespread use of technology and social media has not only changed how but when they achieve developmental milestones and created emerging clinical issues that need addressing. At the same time, improvement in the awareness and treatment of mental health illness in children and

adolescents, in conjunction with academic accommodations, has allowed more young adults with mental health illnesses to advance to secondary education, and there have been identifiable trends in scope and severity of cases. These students are expected to meet the academic standards of their peers while learning to manage their illness. The very nature of college experience has been transforming. Globalization poses unique challenges to providing mental health treatment and psychiatric services for an international, diverse and exceptionally mobile patient cohort. The psychiatric workforce must be culturally competent and able to communicate with various providers, in and outside their institutions to improve transitions of care and prevent relapse. Tele-psychiatry shows promising results in overcoming some of these hurdles, although we still lack legislation that facilitates care across state lines and certainly across national borders, so students can continue care during time away from school. Last, but certainly not least, legalization of cannabis in several states has increased the number of college students who openly consume it for medical or leisurely purposes. Its presence on campus has created clinical dilemmas for college providers by triggering new onset of severe mental illness, worsening the prognosis of an existing one, or creating an obstacle when treating certain conditions, i.e. ADHD. The need to treat a wide range of diagnosis as well as to fulfill diverse roles, from prescriber to therapist to advocate has increased the burden of college mental health providers. The objective of this session is to highlight the clinical and legal predicaments of the modern college psychiatrist practicing in these new frontiers of college mental health, illustrating it with case examples and to summarizing recent literature of best practices.

New Guideline Recommendations for Strengthening Psychiatric Practice

Chair: Laura J. Fochtmann, M.D.

Presenters: Catherine C. Crone, M.D., Victor Ivar Reus, M.D., George Alan Keepers, M.D.

Discussant: Daniel J. Anzia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe potential benefits of

using evidence-based guidelines in clinical psychiatric practice; 2) Discuss the ways in which the amount and quality of relevant research evidence shapes the development of clinical practice guideline recommendations; and 3) List at least 3 APA practice guideline recommendations related to treatments for eating disorders and/or schizophrenia

SUMMARY:

Practice guidelines act as a vehicle for bringing state-of-the-art evidence, including new innovations in care, to the attention of clinicians, with the ultimate goals of improving quality of care and patient well-being. Practice guidelines are of increasing value to psychiatrists by synthesizing advances in research and providing consensus-based guidance when research evidence is unavailable. With the shift to quality based payment methodologies, practice guidelines will take on even greater importance. This presentation will provide an overview of APA's practice guidelines program and discuss some of the challenges that arise in developing practice guidelines. New practice guideline recommendations relating to the treatment of schizophrenia and eating disorders will be reviewed along with a description of the evidence that underlies key recommendations. Plans for future guideline topics, including bipolar disorder and borderline personality disorder, will also be discussed. Attendees' views on knowledge gaps and guideline-related needs for information will be solicited on these topics. The program will foster an exchange with attendees about implementing guideline recommendations in psychiatric settings. Attendees will be encouraged to give examples of successes and challenges of adopting practice guideline recommendations in their own practices. They will be asked to share their preferences for accessing guidelines (e.g., web, textbooks, pocket cards, phone apps) and offer suggestions for making guidelines more useful in their daily practice.

No One Trick Pony: Adapting Integrated Care in Diverse Primary Care Settings

Chair: Lori E. Raney, M.D.

Presenters: Lori E. Raney, M.D., Ken Hopper,

Matthew Louis Goldman, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe at least 2 approaches beyond the CoCM for integrating primary care and behavioral health; 2) List several of the core elements of effective integrated care to consider individually or in combination; and 3) Understand various roles psychiatrists can fill as team members in a primary care practice

SUMMARY:

Integrating primary care and behavioral health is vital to addressing access to behavioral health care and decreasing overall health care costs. To address this, the APA received a grant to train 3,500 psychiatrists in the highly effective and cost saving Collaborative Care Model (CoCM). The role of the psychiatrist in this model shifts to that of a caseload consultant which allows a population based approach to leverage psychiatric expertise to more people in need. However, upon completion of the course many psychiatrists face a lack of opportunity in which to practice what they have learned. This is due to a variety of factors including the majority of payers not reimbursing for the CoCM CPT codes, and the heavy implementation lift required to implement the model in busy and cash strapped primary care practices. Instead, psychiatrists find themselves being asked to join primary care practices that are approaching integration in numerous ways that may lead them to think they are doing integration in a manner that, since it is not "evidence-based", perhaps it is not worth doing at all. This belief could alienate us from our primary care and other behavioral health colleagues and limit access to the important expertise and skills we have to offer. We are at a point where new strategies to work with primary care teams are needed and in fact are happening. Digging into the heart of what makes the CoCM so successful and implementing any one or combination of these features as resources become available is an important contribution. Components of CoCM including measurement-based care, frequent outreach, and using a registry to track progress are important ways to begin the process. Convincing a practice of the benefit of forgoing some portion of conventional revenue to use for the psychiatrists time to do case reviews, be available for curbside consultations or education all add up as a primary care practice builds towards a more

complete rendition of the CoCM. This session will look at how this is already occurring through a variety of lenses including that of the audience. The presenters have been in the roles of payer (Dr. Ken Hopper), technical assistance practice coach to a State Innovation Model (SIM, Lori Raney, MD), and a recently graduated ECP involved in the development of the Montefiore's Continuum Based Framework (Matt Goldman, MD) who have all seen first-hand how variation in practice must be recognized and embraced to move the field forward. The audience supplies yet another rich resource of knowledge in these variations and will be tapped for their experience during the course of the session. After brief descriptions of the presenters' experiences, an innovative learning approach called Liberating Structures will be used to engage the audience and elucidate their encounters in real world practices. Several processes such as Impromptu Networking and 1-2-4-All will be utilized and ideas collected for the audience to consider.

No Poster, No Publication, No Problem: A Step-by-Step Guide to Get You Started in the Scholarly Activity Process

Chair: Rashi Aggarwal, M.D.

Presenters: Rober Aziz, M.D., Banu O. Karadag, M.D., Faisal Kagadkar, M.D., Gezel Saheli, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify barriers to productivity in the scholarly activity process; 2) Participants will be able to describe concrete steps towards choosing a topic for an abstract.; and 3) Participants will be able to develop their own ideas for abstracts or publication

SUMMARY:

Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, many residents lack the necessary skills for choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. The goal of this workshop is to assist participants with scholarly

activity at the beginner level –whether medical student, resident, fellow, or practicing physician We will provide practical tips on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. These guidelines are not only helpful for potential writers, but are also useful for residency program directors and faculty interested in fostering scholarly activity. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports. During this workshop, we will offer examples of scholarly activities by residents in our own program. Our residents have had over 100 presentations at national meetings and over 50 publications in the past 5 years. This is in comparison to a previous precedent of only a few posters presented per year, which highlights the utility of our proposed tips. Our workshop will be highly interactive and the process of taking a rough idea and then narrowing it into a research question will be demonstrated by role-play. Participants will be able to discuss some of their own research ideas or ideal patients for case reports and will be guided through the process in order to be more prepared to tackle their first poster or first publication. By the end of this workshop, participants will be better equipped with practical knowledge of progressing from the inception of an idea to completing a scholarly activity.

Ohm Versus Om: Resistance to and Efficacy of Various Meditation Modalities in the Military

Chair: Daniel C. Hart, M.D.

Presenters: Brett T. Thomas, M.S., Jaremy Jon Hill, D.O., Sarah McNair, M.D., Bhagwan A. Bahroo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe primary forms and applications of meditation in the military; 2) Confront personal and institutional bias in considering of meditation as a treatment; and 3) Engage discomfort in broaching spiritual topics and enhance cultural competency

SUMMARY:

Background: For many, the idea of meditation often conjures images of chanting a mantra, sitting quietly or simply stating the word “Om” (pronounced Auhm). This image may not readily translate into the clinical setting and even more so, may clash with the notion of meditation in a warfighting institution like the US Armed Forces. Indeed, although meditation is noted in the literature as a means of therapy in the military as early as 1977, its common use has yet to take hold. In an era where pharmacotherapy and psychotherapy are increasingly appreciated as jointly addressing the mind-body dyad, meditation may provide an effective adhesive to connect that duality. Content: This workshop will approach meditation from a bottom up perspective. First, it will give vignettes of both personal and clinical use. Then, it will transition to a broad discussion on hesitancy to engage in alternative treatment modalities that fall within the broad umbrella of meditation to include mindfulness, grounding, Christian meditation and prayer, transcendental meditation, and yoga. It will allow for a robust discussion on the use of meditation and provide resources and contacts for training and future work in this field. A real-time online forum will be used to solicit and respond to comments in addition to a traditional feedback session.

Patient Suicide in Residency Training: The Ripple Effect

Chair: Marina Bayeva, M.D., Ph.D.

Presenters: Stephanie Martinez, M.D., Rachel Renee Thiem, M.D., Deepak Prabhakar, M.D., M.P.H., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) to identify challenges in supporting trainees who experienced patient suicide; 2) to present data on development of educational curricula related to patient suicide; 3) to share residents' personal experiences with patient suicide; and 4) to provide a forum for discussion of issues surrounding patient suicide in residency

SUMMARY:

Suicide is a major public health concern, which has been ranked as the tenth leading cause of death and claimed 44,965 lives in 2016 according to the report

by the Center for Disease Control and Prevention. Studies estimate that 20-68% of psychiatrists will lose a patient to suicide during their career. A significant number of residents will experience patient suicide in their training, yet open discussions about the issues and feelings raised in response to suicide remain rare in residency training programs and scant in published literature. This silence may be due to feelings of shame, loss, fear, confusion and other emotions not only in residents, but also in their colleagues and supervisors, after a patient dies by suicide. Importantly, shying away from discussions of the impact of patient suicide interferes with residents' ability to cope with this painful event and may even exacerbate their struggles. It has become clear that residency training programs need to actively support residents throughout this difficult experience and to prepare them for the likelihood of losing a patient to suicide during their careers. The symposium will begin with residency training directors examining the challenges in educating trainees about the impact of patient suicide, illustrated through a video titled “Collateral Damage: The Impact of Patient Suicide on the Psychiatrist.” This video was developed as a discussion stimulus for residents, faculty, and private practice psychiatrists to help foster their understanding of the experience of losing a patient to suicide. Next, psychiatry residents from various training programs across the United States will share their personal stories of coping with a patient's death by suicide. Small group discussions led by panelists will follow, providing an open forum for sharing experiences with patient suicide among audience participants. To provide more practical guidance, we will present data from a study by Prabhakar et. al. which examined the role and development of support systems, including educational curricula, for residency training programs. This study showed an increased awareness of issues related to patient suicide in residents who underwent the training, highlighting potential benefits of its broader implementation. The symposium will end with a large group discussion of strategies for improving supports for residents and a forum for questions from the audience.

Pharmacogenetics for Personalized Psychiatry: Pipe Dream or Paradigm Shift?

Chair: Michael D. Cooper, M.D.

Presenters: Fayrisa Ilana Greenwald, M.D., Jesse Koskey, M.D., Brittany M. Heins, M.D., Benjamin Abbott Solomon, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand when it is appropriate to use genetic testing in psychiatric treatment; 2) Interpret genetic testing in a clinically meaningful way; 3) Communicate the meaning of genetic testing results to patients in a clear and concise manner; and 4) Appreciate the costs and ethical implications of genetic testing

SUMMARY:

Psychiatric genetic testing became commercially available in the early 2000s. Every year, an increasing number of Americans in Mental Health treatment are undergoing genetic testing. Psychiatric genetic testing has received extensive media attention and direct advertising to clinicians by genetic testing companies. In the burgeoning era of personalized medicine, many patients are presenting to practitioners expecting genetic testing. However, the utility of genetic testing in clinical practice has not yet been clearly established. The clinical benefits of this testing in its current form may be overstated for the general population of psychiatric patients. While these assays may be useful for a subset of patients, clinicians should develop strategies to determine patients who will likely benefit from this intervention. Caution should be used when ordering testing and communicating results as patients may misinterpret or over interpret the data. This workshop focuses on critically analyzing the available data on the usefulness of genetic testing for treatment selection in mental health patients. Participants will be provided with summaries of major studies used in genetic testing and will apply these studies to a sample case. Participants will use the outcome of this analysis to develop a treatment plan. The group will focus on methods of discussing genetic testing with patients. This session will also include a participant-driven discussion of the potential costs and ethical implications of ordering genetic testing.

Physician Aid in Dying: A Closer Look at the Psychiatrist's Role

Chair: John Raymond Peteet, M.D.

Presenters: Rebecca W. Brendel, M.D., J.D., Marie Nicolini, Karandeep Sonu Gaiind, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the historical precedents and ethical issues facing psychiatrists involved with EAS; 2) Articulate the factors involved in assessing emotional and cognitive capacity to request EAS; 3) Recognize potential areas of concern in prescribing EAS for individuals with personality disorders; and 4) Appreciate the challenges of formulating policy governing the role of psychiatrists in this area

SUMMARY:

Physician aid in dying (PAD) is now legal in several jurisdictions in the US, and Canada recently legalized euthanasia. As a result, psychiatrists are increasingly being asked to assess the emotional state and decisional capacity of individuals requesting PAD. Furthermore, euthanasia or assisted suicide (EAS) for psychiatric disorders is legal in some countries, but remains controversial. Presenters in this session will examine the issues confronting psychiatrists faced with patients requesting aid in dying. Dr. Rebecca Brendel, a bioethicist at Harvard Medical School will consider the broad legal and clinical authority psychiatrists have historically been given in preventing suicide in relation to their new roles where aid-in dying laws are being adopted – specifically the challenge of distinguishing between desires to end one's life in the setting of terminal illness and suicidality related to mental illness. Dr. John Peteet, a C/L psychiatrist in a cancer center, will explore how capacity for PAD may differ from capacity to refuse a treatment, where the physician's action implies crossing the bodily integrity of an objecting patient. Perhaps in the context of PAD where a physician is deciding whether it is appropriate to offer a lethal intervention, a broader conception of what is important and allowable is needed, such as a "decision-optimizing" relationship with the patient. Three case examples will illustrate the idea that

what is at stake is not only the patient's cognitive capacity and DSM diagnosis but the patient's emotional capacity, and the professional and clinical responsibility of the doctor to the patient. Even if a physician agrees that PAD is ethically permissible, he will want to see that the patient is making a fully autonomous decision before acceding to his request. Dr. Marie Nicolini, a Belgian trained psychiatrist and ethicist will present a directed-content analysis of all psychiatric EAS cases involving personality and related disorders published by the Dutch regional euthanasia review committees (N=74, from 2011 to October 2017). Findings include that past psychiatric hospitalization and psychotherapy were not tried in 27% and 28% respectively, that in 50%, the physician managing their EAS were new to them, that a third (36%) did not have a treating psychiatrist at the time of EAS request, and that most physicians performing EAS were non-psychiatrists (70%). These factors, and the fact that physicians evaluating such patients appear to be specially emotionally affected compared to when personality disorders are not present, raise questions about entrusting such complex cases to non-psychiatrists, and about their interpretation of EAS requirements of irremediability. Dr. Sonu Gaind, a Toronto psychiatrist and former president of the Canadian Psychiatric Association, will discuss the process of evolving deliberation of these issues within the Canadian context and within the World Psychiatric Association.

Physician Mental Health and Cognition Across the Lifespan

Chair: David M. Roane, M.D.

Presenters: Jeffrey Alan Selzer, M.D., Gayatri Devi

Discussant: Carol Ann Bernstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand salient mental health and cognitive challenges facing physicians at different phases of their career span.; 2) Identify the barriers that prevent physicians from obtaining mental health treatment; 3) Describe the protections that can enable physicians to receive evaluation and treatment without facing adverse consequences; 4) Learn to appropriately approach an impaired colleague or friend to discuss their condition; and 5)

Learn to become an advocate in your own professional community for colleagues with mental health or cognitive issues

SUMMARY:

Medicine is a rapidly evolving profession with daily challenges requiring sustained preparation, vigilance, and dedication. Professional demands take a personal toll throughout our career. We battle depression during training years, along with substance abuse as practitioners and, finally, as more of us work longer than ever before, we juggle cognitive loss and dementia with the clinical judgment we prize as physicians. During both medical school and residency, the incidence of new-onset depression increases significantly. This high rate of depression persists after training as reflected by the fact that the rate of physician suicide is higher than in the general population, especially in females. Efforts to intervene early may be critical. While substance use can be a major problem for physicians at any time, it is often not identified until it leads to impairment at work, and endangers the physician's ability to stay in training or practice. Studies show that at-risk alcohol use is significantly greater in medical students than in aged matched controls. In practicing physicians, rates of alcohol use disorders are higher than in the general population, with rates being highest in female physicians. Depression and burnout are correlated with substance use problems. Although state physician health programs produce excellent outcomes for participants, prevention approaches deserve further study. Senior physicians are a critical component of the physician workforce and are invaluable as mentors and leaders. Of the 95,000 actively licensed American physicians 70 years of age and older, an estimated one quarter have dementia or cognitive impairment significant enough to interfere with functioning. Additionally, understanding the heterogeneity of cognitive disorders is key, particularly as this pertains to the physician and his or her scope of practice. In the case of all these challenges along the course of a physician's working life, there are major barriers that prevent physicians from receiving appropriate evaluation and treatment. These barriers include lack of time, stigma, and the possibility of a negative consequence for the career of the physician, including fear of reprisal from

patients and colleagues. When a beloved physician becomes impaired, colleagues may become protective, rather than encourage the person to seek help as they too might fear for the patient's livelihood. On occasion, particularly further along in the course of illness, the physician may lack insight and refuse treatment. This session will focus on how these barriers can be effectively addressed at different career stages and how access to needed interventions can be enhanced. There are established agencies in place in the United States to help assist such persons, and allow them to remain working, with oversight, but many of us are unaware of this recourse. The unique role that psychiatrists can play to support their fellow physicians will be emphasized.

Pioneering Projects Within the Field of Emergency Psychiatry

Chair: Jurgen Eelco Cornelis, M.D.

Presenters: Erik Peter Kornelis Sikkens, M.D., Jurgen Eelco Cornelis, M.D., Ansam Barakat, Hans Nusselder

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and discuss a new form of cooperation between police officers, public prosecutors and mental health care providers.; 2) Discuss the challenges of executing a multicentre randomized controlled trial (RCT) within the context of acute psychiatry.; 3) Learn about the preliminary results of the RCT, in which intensive home treatment (IHT) outcomes were compared with standard care outcomes from regular admissions.; 4) Discern the clinical significance of the identified risk factors for admission of patients receiving Intensive Home Treatment (IHT).; and 5) Analyse the experiences of a small, acute care, triage ward over fifteen years.

SUMMARY:

In a series of interactive lectures we will present findings from three pioneering projects within the field of emergency psychiatry: screening of psychiatric patients in police custody, Intensive Home Treatment (IHT) and a triage ward programme. In Amsterdam, mental health care providers, police services and public prosecutors were dissatisfied with the treatment of psychiatric

patients who were in police custody due to insufficient exchanges of information between the relevant parties. Therefore, we introduced a pilot project that incorporated a face-to-face consultation by a psychiatrist with a direct and timely exchange of information between that psychiatrist and the public prosecutor. The goals were firstly, to have the psychiatric consultation take place within two hours of being taken into police custody, and secondly, that if the decision for compulsory psychiatric admission was made, admission would be effectuated immediately. The study was conducted with 119 participants. Herein, we discuss the pilot project and its outcomes. The importance of community mental health care initiatives has been promoted, owing to the advocacy of patient rights movements and relevant political and financial stakeholders pursuing better outcomes. In the field of emergency psychiatry this has led to the creation of Crisis Resolution Teams (CRT's) in the Netherlands named Intensive Home Treatment (IHT) teams. These teams provide short, intensive treatment for psychiatric patients and their relatives within their home setting. For this project, a multicentre, randomized controlled trial (RCT) compares IHT with existing low-intensity outpatient care and hospitalisation methods. Primary outcomes are measured by the number of days admitted; secondary outcomes include psychological well-being and the welfare of patients and their relatives. 240 participants were included in the study, of which, 160 were allocated to IHT. Approximately 48 per cent of these participants had been hospitalized for at least one day by week 6, post-randomisation. Variables associated with hospitalization will be clustered in socio-demographics, clinical characteristics and history of health care use. The challenges of executing this research with 240 participants being in crisis, baseline outcomes and the significance of the identified risk factors will be discussed. Fifteen years ago the Psychiatric Emergency service Amsterdam (PESA) experienced systematic problems with the admission of psychiatric patients, therefore, a triage ward was pioneered to serve as intermediate screening unit between PESA and the psychiatric ward. We will review the operation of this ward over the past fifteen years within the context of changes, including organizational changes to psychiatric care and

demographic developments in Amsterdam. The aim is to provide insight into epidemiology, the extent of compulsory treatment and the referral to the internal psychiatric wards of this triage ward.

Podcasting in Psychiatry: Listening, Creating, and Transforming the Mental Health Learning Landscape

Chair: Mehul V. Mankad, M.D.

Presenters: Ann Thomas, Paul Gauci, Aarti Rana, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what educational needs are being met by mental health podcasts among psychiatric trainees, licensed clinicians, and the general public; 2) Appreciate the development, production, and dissemination of topics in mental health via the podcast medium; 3) Examine the technology involved in podcast construction and distribution; and 4) Critically evaluate the role of podcasting in the larger context of medical education

SUMMARY:

Modern psychiatrists and their patients exist in an era of unprecedented access to information. The internet often serves as a primary or secondary source of health information for many patients, and an increasing number of healthcare providers themselves turn to internet resources for information rather than traditional sources to advance their own medical knowledge. Among available digital resources, podcasts created by mental health clinicians and researchers fulfill a critical role in dissemination of high quality information to audiences asynchronously. Podcasts can be designed to appeal to a wide audience and to educate the public on topics within mental health. These podcasts have the added value of decreasing stigma and sharing information freely with individuals with limited access to expert resources. Alternatively, podcasts can be used in a targeted manner to teach specific cohorts of clinicians from a canon or rubric. Podcasts can even be used in a flipped classroom model as a supplement to didactic instruction. Our session combines the experience of producers of four mental health podcasts from the

U.S., Canada, and the U.K., each with distinct subject areas within psychiatry and with different intended audiences. During this session, participants will understand the goals behind mental health podcasts and the reason underpinning their development. They will learn about needs being met by mental health podcasts and the reception of these products in the learning environment. Panelists will provide participants with knowledge about podcast production, technology, and dissemination, with the focus of helping participants to develop their own message. Panelists will share their own development narrative as well as discuss obstacles and ethical questions encountered. Finally, panelists will discuss the role of podcasts in the educational landscape, particularly in relation to certified continuing medical education content that may also be available digitally.

Policing and Mental Health: How Can Psychiatrists Help?

Chair: Margaret E. Balfour, M.D., Ph.D.

Presenter: Chris Magnus

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify ways in which law enforcement and behavioral health systems can work together to help people with behavioral health needs before and after an emergency response to a crisis.; 2) Describe ways in which psychiatrists can engage with their local law enforcement agencies.; 3) Discuss ways in which behavioral health systems can tailor their clinical and business processes to support law enforcement and first responders.; and 4) Apply the concepts learned in this session to enhance his/her own organization's ability to develop collaborative interventions across the crisis continuum.

SUMMARY:

Individuals experiencing a mental health crisis are at increased risk for contact with law enforcement, too often with tragic consequences. Collaboration between law enforcement and psychiatrists can improve outcomes; however, the intersection of between the mental health and criminal justice systems is complex. Collaborative efforts must not only address the needs of individuals and families in

crisis but also consider public safety and the unique culture of law enforcement. This workshop will outline opportunities for psychiatrists to engage with local law enforcement, illustrated by real-world examples of successful collaborative projects. We will begin with an overview of the current issues, research, and policy recommendations regarding community policing and the law enforcement response to persons with mental illness. Next, we will describe specific areas in which psychiatrist engagement can be particularly helpful, including training, crisis service design, officer wellness, and critical incident review. Then we will describe a real-world example of a successful collaboration - the Tucson Mental Health Support Team (MHST) Model. Developed after the 2011 shooting of US Representative Gabby Giffords, the Tucson Model enhances established models such as Crisis Intervention Team Training with the addition of a dedicated team of officers and detectives focused on intervention before the situation escalates to the point of crisis. Furthermore, behavioral health crisis services are strategically designed to promote pre-arrest diversion by treating law enforcement as a "preferred customer." Both systems track outcomes and metrics that support the business case for this approach. Finally, we will conclude with a discussion in which audience members can discuss successes and challenges in their own communities with our expert panel of law enforcement and psychiatric experts.

Posttraumatic Stress Disorder and Posttraumatic Cinema: Depictions of the Psychological Wounds of War

Chair: Harry Karlinsky, M.D.

Presenter: Andrea Tuka, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Utilize film to teach historical, diagnostic and treatment-related issues central to combat-related PTSD; 2) Appreciate that films that depict traumatic events may retraumatize vulnerable viewers; and 3) Adopt a trauma-informed pedagogical approach when utilizing films to teach about or to help treat PTSD.

SUMMARY:

The presenters will demonstrate how specific feature films and documentaries can be utilized as educational vehicles to address specific teaching points concerning combat-related Posttraumatic Stress Disorder. Beginning with cinematic representations of World War I, World War II and Korean veterans that predate contemporary understanding of PTSD, we then demonstrate how cinematic depictions shifted to the post-war experiences of the Vietnam veteran. Selected clips from more current films related to combat in Iraq and elsewhere will then be utilized to introduce new cinematic themes including a focus on the concept of moral injury, the female service member/veteran, the destructive impact on the affected individuals' family members, and a multitude of societal and healthcare challenges associated with recovery and/or reintegration into civilian life. The genre of posttraumatic cinema will also be utilized to effectively illustrate how healthcare providers, peacekeepers, and civilians situated in areas of conflict are also frequently victims of PTSD. Finally, in the context of utilizing films to teach about PTSD, or even potentially to help treat those with PTSD, we discuss the potential risk of retraumatizing vulnerable individuals. Recommendations that facilitate a trauma-informed pedagogical approach will be shared.

Prescribing Medication for Opioid Use Disorder Through Telepsychiatry: An Innovative Approach to Expand Treatment

Chair: Christopher J. Welsh, M.D.

Presenter: Eric Weintraub, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how rural America has been impacted by the opioid epidemic and identify causes of the disproportionate impact; 2) Describe barriers that restrict access to evidence based Medication Assisted Treatment in underserved areas; 3) Describe models to utilize telemedicine to prescribe buprenorphine in underserved rural areas; 4) Describe strategies for addressing regulatory hurdles to prescribing controlled substances using telemedicine.; and 5) Describe three benefits to using telemedicine to provide behavioral health services

SUMMARY:

The United States is in the midst of an opioid epidemic and rural America has been disproportionately impacted. Medication Assisted Treatment (MAT) with methadone and buprenorphine are evidence based agonist treatments for opioid use disorder. However, numerous barriers exist and restrict access to MAT in rural/underserved areas. The use of telemedicine to deliver psychiatric services to underserved populations is demonstrated to be safe and effective. Various logistical and regulatory barriers have made the treatment of opioid use disorders with MAT using telemedicine extremely challenging. The University of Maryland SOM began providing buprenorphine treatment to patients with opioid use disorders via telemedicine in August 2015 and is currently providing this service to four different sites in underserved areas of rural Maryland. In the spirit of the theme of this year's APA Annual Meeting, "Revitalize Psychiatry: Disrupt, Include, Engage, and Innovate," this presentation will describe the impact of the opioid crisis on rural America, barriers to access to MAT in rural areas and a description of the implementation of telemedicine delivered buprenorphine at six different rural sites in Maryland. Data will be presented describing outcome data of a retrospective chart review of the first 177 patients treated examining retention in treatment and rates of continued opioid use. Treatment retention was 98% at one week, 91% at one month, 76% at two months, and 59% at three months. Of those patients still engaged in treatment at 3 months 94% had stopped using illicit opioids. Participants will discuss various components necessary to establish and maintain a successful telemedicine program for prescribing buprenorphine and how such programs can be established in various areas of the country.

Preventing Suicide in the CL Service

Chair: Tatiana A. Falcone, M.D.

Presenters: Jeanne M. Lackamp, M.D., Fernando Espi Forcen, M.D., Ph.D., Youssef Mahfoud, M.D., Ruby C. Castilla Puentes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to recognize risk of suicide in different CL services; 2) Participants will be able to understand the importance of screening for suicide in populations with chronic illness that are at higher risk; and 3) Participants will identify how substance abuse can increase the risk of suicide in populations at risk

SUMMARY:

Evaluating the risk of suicide is probably one of the most frequent consults in the CL service. Over the last 20 years, suicide rates have been increasing worldwide. Although the prognosis of suicide is complex, key psychosocial risk factors have been recognized to help identify individuals who may be at immediate risk. Certain chronic illness increase the risk of suicide. The objective of this presentation will be to help psychiatrist identify the risk factor of suicide in several chronic illness, to promote increase integration of care and early screening to prevent suicide in the CL service. Multiple studies have demonstrated that some CL patients are at higher risk of dying by suicide compared with the general population and other chronic illnesses. We will move from the general to the particular, first we will discuss key general practices that can be more helpful preventing the risk of suicide in the CL service and then specifically we will review key factors preventing suicide in patients at higher risk of suicide; epilepsy, palliative care, comorbid substance use disorders (SUD) and patients with dementia We will review practices to prevent suicide on the CL service at 4 different institutions; University Hospitals (CWRU), Cleveland Clinic, VA hospital, Rush. Dr. Lackamp will focus on the general guidelines to prevent suicide in the CL service. The other 4 presenters will review the following 4 topics in the specific illness, the final 15 minutes will include a panel and audience discussion. Conclusion: Regular screening for suicidal thoughts in the CL service is imperative, specific risk factors to stratify the risk in several comorbidities will be discussed

Psychiatry in the Courts: APA Confronts Legal Issues of Concern to the Field

Chair: Marvin Stanley Swartz, M.D.

Presenters: Howard V. Zonana, M.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases; 2) Appreciate the issues involved in standards for discharge planning of individuals with mental illness discharged from criminal justice settings.; and 3) Discuss the issues involved in application of the death penalty in cases involving mental illness or cognitive impairment

SUMMARY:

The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year, and to provide their input concerning APA's role in these cases. Three cases will be summarized and the issues they raise will be addressed: 1) *Charles v. Orange County* involves standards for discharge planning of individuals with mental illness being released from criminal justice custody; 2) *Madison v. Alabama* involves application of the death penalty in an individual with mental illness and cognitive impairment; 3) *Commonwealth v. Eldred* involves a challenge to the use of jail sanctions for an individual with substance misuse on violating terms of probation by continuing to use substances. Since new cases are likely to arise before the annual meeting, the Committee may substitute a current issue on its agenda for one of these cases. Feedback from the participants in the workshop will be encouraged.

Psychiatry's Role in Understanding Current U.S. Political Polarization

Chairs: Jacob Elliott Sperber, M.D., Trygve Dolber, M.D.

Presenters: Kenneth Stewart Thompson, M.D., Arlie Hochschild

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List a psychological, social,

economic, and political factor involved in increasing polarization of American voters.; 2) Explain how these factors at different levels interact to produce a political gulf in communication.; and 3) Offer 2 proposed solutions to address the widening political gulf.

SUMMARY:

Psychiatry's Role in Understanding Current US Political Polarization Where do psychiatric concepts fit into the analysis and understanding of the conservative shift and dramatically increased political polarization demonstrated in the 2016 election? After a summary of the accelerating political polarization, participants will discuss their experiences of the polarization. Next a review of literature which has analyzed the shift and polarization, attributing them to economic, political, social, cultural, racial, gender, geographic and psychological variables, as well as unresolved charges of collusion with a foreign power. A picture emerges of older, white, non-college, working-class and lower middle-class men once employed in blue-collar and lower white-collar jobs that have left the economy. They feel trapped between economic and political elites above, and poor minorities below. Politically many of these voters have formed a core of support for the President, unshaken by his pursuit of policies which have not favored their economic interests. This administration also has engaged in inhumane treatment of immigrants, separating children from parents, inconsistent with American values. Some analysts see the polarization and values loss as correlated to a breakdown in the political processes of communication and negotiation, creating a gulf between political poles, a disappearance of empathy, an unwillingness to communicate, negotiate and compromise. Sociologist Arlie Hochschild (*Strangers in Their Own Land*, 2016) applies her sociology of emotions, seeking reconciliation through emotional understanding of ideological opponents. Her interviews with Tea Party supporters in Louisiana uncover a deep resentment of perceived liberal attitudes. By relating the "deep story" of the emotions of her subjects, she opens the reader to an empathic understanding of their worldview. Drawing from motivational interviewing and relational psychotherapy, the workshop addresses this "failed

empathy” with the view that public discourse must include mutual listening, each side validating the needs and wants of the other. Political rhetoric which vilifies minority groups –black athletes as un-American, immigrants as rapists, gays as not fit for military, all Muslims as terrorists – functions powerfully to reinforce splitting, a negation of self-criticism. The “deep story” view will be compared with explanations that attribute the gulf to ideological factors and prejudice, cult models, and corrupt manipulation by economic interests. These alternative views hold that there are groups on the extremes who hold beliefs as cult ideologies, have no interest in evidence, and will not listen to arguments. Participants will discuss their views of the factors. The final substantive part of the presentation, led by guest sociologist/author Arlie Hochschild, PhD, will address solutions and future trends, followed by discussion of these issues and brief evaluation.

Psychopharmacology Algorithm for Obsessive-Compulsive Disorder

Chair: Ashley M. Beaulieu, D.O.

Presenters: David Neal Osser, M.D., Edward Tabasky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Diagnose obsessive compulsive disorder (OCD) by the DSM-5 criteria and be familiar with the evidence-based literature supporting commonly-used first-line medications for OCD.; 2) Understand psychopharmacological options for treatment-resistant OCD and consider alternative approaches for patients who have comorbidities that would change the standard algorithm.; and 3) Access the OCD algorithm developed by the Psychopharmacology Algorithm Project at the Harvard South Shore Program on the internet, at the website www.psychopharm.mobi.

SUMMARY:

Background: The Psychopharmacology Algorithm Project at the Harvard South Shore Program was founded in 1993 and it consists of evidence-based recommendations considering efficacy, tolerability and safety. A previous algorithm for obsessive compulsive disorder (OCD) to which we contributed

was published in 2012. New studies suggest that an update is needed. Methods: The references reviewed for previous algorithms were re-evaluated and a new literature search was conducted to identify studies that could either support or alter the previous recommendations. We considered exceptions to the main algorithm, such as patients with bipolar disorder, women of child-bearing potential, and patients with common medical comorbidities. Algorithm Summary: A trial of a selective serotonin reuptake inhibitor (SSRI) including fluoxetine, sertraline, or fluvoxamine for 8-12 weeks is still the first line medication treatment. If the patient has a partial but unsatisfactory improvement after 4-6 weeks on a moderate dose, the next step is to titrate to the usual maximum dose. If there is no response, it is recommended to check a plasma SSRI level for non-adherence and ultra-rapid metabolism. If there is no improvement on an SSRI at the maximum recommended dose, the next step is to try another SSRI (preferred) or clomipramine. If the response to a second SSRI at moderate dosage is unsatisfactory, it is again recommended to titrate to the maximum dose and check plasma levels. This trial differs in that if the patient does not respond at the maximum dose, one may consider pushing the dose beyond the Food and Drug Administration approved maximum. This is based on weak evidence but the alternatives (augmentation strategies) could have more side effects. If there is no or inadequate response to the second SSRI, the next recommendation is to augment it with a second-generation antipsychotic (SGA), specifically aripiprazole or risperidone. If there is still an unsatisfactory response, augmentation with novel agents can then be tried, but they might be preferred if the side effects of SGAs would be unacceptable. The efficacy of these novel agents theoretically occurs via modulation of glutamatergic (memantine, riluzole, topiramate, n-acetylcysteine, lamotrigine, ketamine) or dopaminergic (ondansetron) tone or by reducing neuroinflammation (minocycline, celecoxib). If SGAs and novel agents are not effective, the next step could be transcranial magnetic stimulation, though the effect size in the sham controlled studies is quite small. Finally, deep brain stimulation and ablative surgery have been shown to be beneficial for severe and intractable OCD, but remain experimental.

Session Content: In this workshop, the speakers will explain the role of algorithms and present the reasoning justifying the sequence of recommended treatments and the specific medications preferred. There will be ample time for attendees to respond and interact with the presenters.

Racism and Psychiatry: Growing a Diverse Psychiatric Workforce and Developing Structurally Competent Psychiatric Providers

Chair: Morgan M. Medlock, M.D., M.P.H.

Presenters: Danielle Hairston, M.D., Kimberly A. Gordon-Achebe, M.D., Derri Lynn Shtasel, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the past and current landscape for minorities entering the psychiatric workforce.; 2) Name root causes of the dearth of racial minorities in the psychiatric workforce.; and 3) Identify the focus of institutional-level interventions that would be expected to improve recruitment of racial minorities in behavioral health care.

SUMMARY:

This workshop is informed by the content of the recent volume, *Racism and Psychiatry: Contemporary Issues and Interventions* (Medlock et al, eds., 2018). Authors will be joined by thought leaders in the field of diversity and health equity to discuss the dearth of racial minorities in the psychiatric workforce, which has deep roots in structures within and outside of the medical profession. The opportunity to become a physician is itself influenced by historic, economic, educational, and social barriers; once in medical school, there are further deterrents to selecting psychiatry as a specialty. And for those who do make this choice, their experiences in residency training, including their formal education as well as the (usually white) climate of the institutions where they train can be improved or worsened by conscious decisions of residency and department leadership. In addition to expanding the minority workforce, all providers need training that is grounded in principles of race equity and social justice, and that address the role of power and privilege in perpetuating mental health inequities. This workshop explores the challenges of

recruiting minority psychiatrists and the need to embed a race equity framework in the training of all psychiatrists. Panelists will discuss both historical as well as current structural factors that contribute to a predominantly white psychiatric workforce and describe core anti-racism training needed by all psychiatrists. The need for changing traditional institutional culture where power and privilege are normative to one that promotes race equity will be a focus of discussion among panelists and workshop participants.

Racism and the War on Terror: Implications for Mental Health Providers in the United States

Chair: Aliya Saeed, M.D.

Presenters: Ansar M. Haroun, M.D., Andrew Michael Stone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the Competing Definitions of the terms terrorism, terror, and terrorists.; 2) Examine the role of Countering Violent Extremism (CVE) in preventing terror attacks in in United States.; 3) Identify key ethical considerations for mental health professionals in the war on terror; 4) Demonstrate an understanding of the intersection between racism, orientalism, xenophobia and the war on terror; and 5) Recognize key issues for mental health providers who work with American communities that have been most affected by the war on terror.

SUMMARY:

Terrorism, Terrorist, and terror, as well as extremism, are commonly used terms, indeed the United States has been engaged in a War on Terror for many years. However, terrorism and extremism remain poorly defined terms. The issue of what constitutes terrorism has not been resolved, various definitions are used by law enforcement, international and domestic institutions charged to reduce terrorism, as well as within academic discourse. What gets called terrorism is impacted by implicit and explicit biases, and has poor interrater reliability. In the United States, most acts resulting in mass casualty are conducted by domestic terrorists, indeed the data indicates a significant increase in such acts within white supremacist groups.

However, in the domestic context, as well as abroad, the American war on terror has focused almost exclusively on Muslim individuals and communities. Domestically, United States has promoted Countering Violent Extremism (CVE) initiatives which have been a source of much controversy, with accusations by civil rights groups that these are mass surveillance program that unfairly singles out Muslim communities. Mental Health professionals have been involved domestically, as well as abroad, in the war on terror, including the unfortunate involvement with the Enhanced Interrogation Program which has been considered tantamount to torture. While the enhanced interrogation program was clearly deemed unacceptable, there are many areas which are less black and white. The Royal College of Psychiatry has created a position paper on this issue, "Counter-terrorism and Psychiatry." While there has been a significant rise in the sentiments of Islamophobia, xenophobia and white supremacy in the country over the last 3-4 years, American attitudes towards what is considered terrorism have been shaped by racism, orientalism, and xenophobia over a much longer period. Statistically, hate crimes, bullying, and harassment of Muslims have been at an unprecedented level. American Muslim communities are largely composed of persons of color with a significant immigrant population. These factors work together to put them at risks of scapegoating, marginalization, and victimization by individuals as well as institutions. Mental health professionals need to develop awareness and cultural competence to be able to address their mental health issues, as well as act as advocates for their patients.

**Reaching Out for Mental Health Care in Africa:
Research to Improve Access**

Chair: Seggane Musisi, M.D.

*Presenters: Etheldreda Nakimuli-Mpungu, M.D.,
Alexander H. von Hafften, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To describe culturally sensitive mental health services research in Sub-Saharan Africa.; 2) To describe how culturally sensitive research can improve the implementation of applied research in Sub-Saharan Africa communities.; and 3)

To describe how research can improve the implementation of mental health services and clinical practice for rural populations in Sub-Saharan Africa.

SUMMARY:

Persons with psychiatric, neurological and substance use disorders represent a significant and vulnerable proportion of the population in low and middle-income countries (LMIC). These persons are confronted by stigma and are marginalized. Psychosocial disability is great. This is especially true in Sub-Saharan Africa (SSA) where post-conflict communities continue to experience adverse events even though the guns are now silent. Traditional methods of managing psychological distress and mental illness are inadequate and do not prevent consequences to individuals, families or communities. Non-prioritization of mental health by government and non-government organizations (NGOs) exacerbates health care disparities and disease burden. Frequent drivers of poor access to mental health services in these rural communities include: remoteness due to long distances and poor road systems; lack of an adequately trained workforce; erratic or inadequate supply of medicines and other material resources; poverty with the consequent lack of money for individuals to reach health clinics or purchase medications; lack of awareness and the importance of psychological distress and mental illness; and the absence of universal health care insurance. This symposium highlights innovative research in culture-sensitive interventions that are feasible, affordable, and effective. 1. The Effect of Group Support Psychotherapy for Depression Treatment among persons with HIV, Delivered by Trained Lay Health Workers in Uganda by Ethel Nakimuli-Mpungu, MD, PhD. 2. The Friendship Bench: The Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe by Dixon Chibanda, MD, PhD. 3. Improving Access Mental Health Care in Rural Africa: Training VHTs to Integrate Mental Health Interventions into Routine Work in Uganda by Alexander von Hafften, MD, DFAPA. 4. Using Mobile Mental Health Clinics to Increase Access to Mental Health Care in Post-Conflict Rural Uganda by Seggane Musisi, MD, FRCP.

Reducing Health Care Disparities Through Careers in Public Service: Lessons From Three Educational Tracks in Public/Community Psychiatry

Chairs: Enrico Guanzon Castillo, M.D., Nichole I. Goodsmith, M.D., Ph.D.

Presenters: Christina V. Mangurian, M.D., Lawrence Malak, M.D.

Discussant: Stephanie Le Melle, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least 3 critical ingredients of public/community psychiatry educational tracks in residency programs; 2) Identify at least 2 facilitating factors at each institution that aided the development of public/community psychiatry educational tracks; 3) Identify at least 2 aspects of public/community psychiatry educational tracks that facilitate education about health disparities, health equity, and the social determinants of mental health; and 4) Identify at least 3 ACGME core competencies that can be taught with the aid of public/community psychiatry curricula in psychiatric residency programs

SUMMARY:

Public/community psychiatry involves clinical care in publicly-funded settings, typically involving care for diverse and medically underserved populations. Public psychiatry tracks encourage careers in public service to help address disparities in mental healthcare access. They also aim to address disparities in quality of care through high quality training of clinicians to provide services for populations often experiencing the greatest health and social inequities. Education in public psychiatry promotes a strong foundation in diverse psychiatric scholarship, including implementation science, quality improvement, and health services/policy research. Public psychiatry education in residency also aids in the teaching of structural competency and strategies to address social determinants of mental health, relevant to all ACGME core competencies, especially the teaching of systems-based practice. Educational tracks within psychiatric residency programs have been shown to increase resident interest in sub-specialty careers and academic productivity (e.g., peer-reviewed

publications). This workshop will highlight public psychiatry educational tracks in three academic residency programs. These programs offer specialized didactics, clinical elective opportunities, and focused mentorship to encourage the development of leaders in public psychiatry. They differ in the extent of their partnerships with county mental health departments, research emphasis, internal resident leadership opportunities, and venues for mental health policy advocacy. To encourage active audience participation throughout the general session, this program will employ an interactive panel discussion. This format will encourage dialogue among the faculty and resident presenters from the three residency programs and active audience participation through questions and comments throughout. The presenters will identify the critical ingredients of these educational tracks and operationalize their development for audience members interested in creating similar tracks at their programs. The discussant will contextualize these programs' characteristics based on her medical education research on public psychiatry residency and fellowship curricula nationwide.

Resources From the Higher Education Mental Health Alliance (HEMHA): Telemental Health on College Campuses

Chairs: Amy W. Poon, M.D., Shari Robinson

Presenters: Kathryn Alessandria, Chris Corbett, Anthony Leon Rostain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Model and demonstrate interdisciplinary collegiality, consensus-building, and co-leadership among 9 organizations in the field of college mental health.; 2) Participants will learn about the college mental health white papers and guides that have resulted from this collaboration, and access this free resource for their colleges and universities; 3) Participants will hear an in-depth presentation on the most recent guide about providing telemental health services on college campuses.; and 4) Participants will discuss and give feedback on the next topic we are currently writing about: service animals and emotional support animals on college campuses.

SUMMARY:

This session will model the interdisciplinary collegiality and collaborative process of the Higher Education Mental Health Alliance (HEMHA), which includes representatives from 9 organizations that focus on higher education policy and university/college mental health. These include the American Psychiatric Association, American Psychological Association, American College Counseling Association (ACCA), American College Health Association (ACHA), American College Personnel Association (ACPA), Association for University and College Counseling Center Directors (AUCCCD), the Jed Foundation, NASPA – Student Affairs Administrators in Higher Education, and the American Academy of Child and Adolescent Psychiatry (AACAP). This collaboration has resulted in several white papers co-written by all the organizations. These are free resources that college mental health providers and university administrators may find useful in providing guidance on various topics. We will present our latest paper on providing telemental health care to students—a 50-page resource document, “College Counseling from a Distance: Deciding Whether and When to Engage in Telemental Health Services.” To address the access issues and unmet demand for affordable, quality mental healthcare in college settings, telemental health has emerged as a modality to be considered in higher education. We will discuss the purpose, scope and limitations of the guide and define telemental health services. We will explore the scope of services and implications, using the guide’s case vignettes as a launching point. We will also discuss updates on prescribing considerations, and review legal and ethical issues. Another topic of interest is that of accommodating and approving requests on college campuses for Emotional Support Animals (ESAs) and Service Animals. We will outline some of the anticipated content on this topic and solicit feedback to identify clinical practice gaps, questions, and controversies. Although HEMHA’s focus is that of higher education, the broader membership can find applicability in both discussion topics above. The presentations will be delivered by visual slides, didactics, and interactive discussion. Attendees will learn perspectives on collaboration, despite differences in multi-organizational cultures and missions, as well as learn about implementing

telemental health services in higher education. Attendees will directly contribute to the development of HEMHA’s next guide, that of ESAs and Service Animals in colleges and universities. We will also briefly summarize and review previous HEMHA white papers on “Postvention: A Guide for Response to Suicide on College Campuses” and “Balancing Safety and Support on Campus.” This program is anticipated to be paired with the 2019 HEMHA Business Meeting hosted by the APA 2019 in San Francisco, attended by representatives from the member organizations.

Responding to the Impact of Suicide on Clinicians

Chair: Eric Martin Plakun, M.D.

Presenter: Jane G. Tillman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Enumerate clinician responses to patient suicide; 2) Implement practical steps for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives; 3) Design a curriculum to educate and support trainees around their unique vulnerabilities to the experience of patient suicide; and 4) List recommendations for responding to the family of a patient who dies by suicide

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Nevertheless, mental health clinicians often have less direct experience with patient death than clinicians from other environments. Each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric physicians because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This presentation surveys the literature on the impact of patient suicide on clinicians, while also offering results from an empirical study carried out by one of the presenters demonstrating 8 experiences frequently shared by clinicians who have a patient commit suicide: [1] Initial shock; [2] grief and sadness; [3] changed relationships with colleagues;

[4] experiences of dissociation from the event; [5] grandiosity, shame and humiliation; [6] crises of faith in treatment; [7] fear of litigation; and [8] an effect on work with other patients. Recommendations derived from this and other studies are offered to help guide individually affected clinicians, but also their colleagues, as well as trainees, supervisors, training directors and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The presentation includes ample time for interactive but anonymous discussion with participants about their own experiences with patient suicide—a feature of this presentation that has been valued by participants in the past.

Revitalize Family Psychiatry: Include, Engage, and Innovate Addressing the Needs of Changing Population and Health Delivery Systems

Chair: R. Rao Gogineni, M.D.

Presenters: Lee Combrinck-Graham, M.D., Ira David Glick, M.D., Suzan Song, M.D., Ph.D., M.P.H., Rakesh Kumar Chadda, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn the indications and contraindications, interventions and the risks and barriers to integration in various treatment settings, and psychiatric disorders. settings, an; 2) Will learn ways of Including, engaging families by making use of Innovative ways to fulfill the treatment needs of changing population and health delivery systems; 3) Will learn ways of working with forcibly displaced populations by augmenting family-centered approach; and 4) Learn to assess familial influences ways of involving family in the management of Substance Use Disorders

SUMMARY:

Family Psychiatrists believe that mental health occurs in a family context, and therefore include families their work, involving family members in assessments, diagnostic formulations, proposed objectives and unfolding treatment. This view of health and mental health requires a complex view of patterns of emotions and behaviors evolving in

interpersonal contexts, in contrast to a mental illness orientation that is individual and symptom focused, and involves a linear process that begins with identifying what is wrong, finding a diagnostic label, and then applying a "therapeutic" solution, often medication. Family Psychiatry is not an illness or disease-oriented approach to the assessment and care of troubled people. In involving families in assessment and treatment, Family Psychiatrists search for resources within the family or immediate community, scan for resilience, far more likely to be found when family members participate, and consequently promote mental health, focusing on the outcomes that involve becoming a member or sustaining engagement as contributing members of communities. Thus when family psychiatrists prescribe medication, it's use is clearly defined in terms of how this will Improve a person's participation in various role functions as a family member with input from the family Substantial benefits have been reported in reducing residual psychopathology, enhancing a fuller remission when pharmacotherapy is integrated with family based treatments in schizophrenic and Bipolar Disorders treatment. Most substance use disorders (SUDs) have onset in young age. Families have an integral role in management of SUDs. Thus any management plan needs to include assessment of familial influences as well as involving family in the management. Educating family about the problem, need of their support in motivation enhancement, treatment adherence, relapse prevention and rehabilitation are important components of family interventions in SUDs Currently, there are about 68.5 million forcibly displaced people in the world, almost half of whom are children. Migration and the situations that create displacement (war and armed conflict), leave families often the only source of support for each other, fragmented from their normal social and cultural lives. Therefore, when working with forcibly displaced populations (unaccompanied and separated minors, refugees, asylum seekers, and survivors of torture), taking a family-centered approach can be critical to understanding and healing. The presentation reviews a succinct history of how family therapy was integrated into general psychiatric practice in the 1970s and subsequently evolved. Examine indications and contraindications in inpatient and

outpatient settings, its efficacy from controlled studies, and the barriers to common acceptance in clinical practice. A special focus will be how psychiatrists use this treatment modality versus how non-psychiatrists understand and use it in practice.

Road Map to Address Health Disparities of U.S. Bipolar Patients of African Ancestry

Chair: Mark Andrew Frye, M.D.

Presenter: Margaret Akinhanmi

Discussants: Eric J. Vallender, Stephen M. Strakowski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand historical contributions to mental health disparities in US; 2) Review bipolar misdiagnosis reasons among patients of African Ancestry; and 3) Identify barriers to minority recruitment for bipolar biobanks

SUMMARY:

While health disparities between patients of African and European ancestry are well documented, there remains a gap in translating known risk factors contributing to disparities into public health initiatives to improve healthcare. This general session will review US health care disparities in bipolar patients of African Ancestry (AA), in comparison to patients of European Ancestry (EA), in the context of US historical diagnostic criteria, course of illness and medication use, research participation, and clinical innovation. The historical misdiagnosis of AA bipolar patients in the context of historical developments in DSM and WHO ICD diagnostic criteria and contemporary clinical factors will be reviewed as contributors to misdiagnosis with a potential racial bias. Anecdotal examples of this phenomenon of misdiagnosis and potential racial bias will be given by the discussant, prompting response and discussion from session participants. Comparison of clinical phenomenology and medication use between AA (n=415) and EA (n=1001) bipolar I patients (obtained from a public database) will be presented. These data will prompt the discussion and importance of better understanding the contribution of differential illness presentation and/or racial bias to this diagnostic disparity. The disparities in recruiting patients of AA

to participate in important studies leave a gap in biomedical research for this minority group and may represent a missed opportunity address potential differences in the disease course of bipolar illness. The presenter will review a new survey study at the University of Mississippi Medical Center designed to better understand issues and concerns surrounding mental health research participation and genetic biobanking specifically among patients of AA . This study was developed recognizing first that genetic biobanks are increasingly important tools in biomedical research for characterizing risk factors for bipolar illness and response to treatment and second that the current participation in bipolar biobanks may not be broadly representative of all populations. Survey results will be presented illustrating how they will be used in the establishment and governance of a genetic biobank that is responsive to patient needs and concerns while encouraging participation and satisfying research goals.

SAMHSA Technology Transfer Center (TTC) in Addiction, Mental Health Services, and Prevention

Chair: Humberto Carvalho, M.P.H.

Presenters: Tristan Gorrindo, M.D., Heather Gotham, Laurie Krom, Holly Hagle, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Integrate knowledge of current psychiatry into discussions with patients

SUMMARY:

This session will introduce the New SAMSHA TTC's. The goal of SAMHSA's TTC network is to accelerate the adoption and implementation of evidence based practices in mental health, addiction and prevention services across our nation; foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers of mental health services;

and to ensure the availability and delivery of publicly available, free of charge, training and technical assistance to the mental health field.

SAMHSA Town Hall

Chair: Anita Everett, M.D.

Presenter: Elinore McCance-Katz, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Integrate knowledge of current psychiatry into discussions with patients; and 5) Identify barriers to care, including health service delivery issues

SUMMARY:

The mission of the US, Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) is to reduce the impact of substance misuse and mental illness on Americas communities. SAMSHA is a small federal agency with a big mission! The last several years have seen a refocusing of SAMHSA so that it is more clearly aligned with the promotion of best practices in the diagnosis and treatment of mental illnesses and substance misuse. This town hall will begin with a brief overview of current SAMHSA initiatives, priorities and opportunities and will culminate with opportunity to listen to the needs of psychiatrists and the patients you serve. Psychiatry has a voice in our federal government and this is intended to be an avenue through which the voice of psychiatry is heard.

Sex, Drugs, and Culturally-Responsive Treatment: Addressing Substance Use Disorders in the Context of Sexual and Gender Diversity

Chair: Jeremy Douglas Kidd, M.D., M.P.H.

Presenters: Faye Chao, Brian Hurley, M.D., M.B.A., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the epidemiology of substance use and substance use disorders (SUDs)

among lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals.; 2) Describe minority stress theory and how this conceptual framework helps explain substance use related disparities among LGBTQ people.; 3) Discuss the differences in substance use among LGBTQ individuals by sexual orientation, gender identity, race/ethnicity, and degree of urbanicity/rurality.; 4) Identify strategies for incorporating knowledge of unique factors in substance use among LGBTQ individuals (e.g., internalized stigma, discrimination, family rejection) into clinical practice.; and 5) Recognize clinical situations where specialist referral and/or consultation would be appropriate.

SUMMARY:

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) people have higher rates of risky substance use and substance use disorders (SUDs) as compared to the general population. These disparities exist across multiple substance categories including tobacco, alcohol, cannabis, and cocaine.

Furthermore, some substances (e.g., crystal methamphetamine) are used within a particular cultural context by a subset of the LGBTQ population. For transgender people receiving gender-affirming treatments, substance use can also have important interactions with these treatments, further increasing the relevance of identifying substance use in this patient population. Minority stress theory (MST) is one conceptual framework for understanding such disparities and posits that individuals from marginalized and/or stigmatized groups experience a unique type of stress that is additive to general stress. Numerous studies have linked MST constructs (i.e., discrimination, prejudice, stigma) to increased risk for substance use and SUDs among LGBTQ people. Clinicians can incorporate such knowledge into clinical practice to tailor treatment in a patient-centered, culturally-responsive manner. This interactive, skills-focused session will utilize clinical case discussion and an audience response system to offer attendees practical tools to facilitate the assessment and treatment of SUDs in LGBTQ populations. We will also utilize a web-based question submission system, allowing attendees to submit questions in real-time during presentations. Attendees will also be provided with a summary handout of key topics and

additional resources to spur further investigation of these topics and incorporation into clinical practice. This session will begin with Dr. Faye Chao reviewing SUD epidemiology in LGBTQ populations. Next, Dr. Petros Levounis will utilize a clinical case involving crystal methamphetamine use to illustrate how minority stress can contribute to the initiation of risky substance use and development of a SUD. Dr. Jeremy Kidd will then discuss tobacco and alcohol use among transgender individuals, including how substance use can impact gender transition related medical/surgical and psychiatric care. Finally, Dr. Brian Hurley will discuss ways in which psychiatrists can translate public health research on SUDs among LGBTQ populations into clinical interventions and strategies for delivering culturally-responsive psychiatric care to LGBTQ people with SUDs.

Shining a Light on Military Sexual Trauma

Chair: Niranjan S. Karnik, M.D., Ph.D.

Presenters: Neeral K. Sheth, D.O., Rebecca Greene Van Horn, M.D., M.A., Melissa Wasserman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1) Review current knowledge and common misconceptions of military sexual trauma (MST).; 2) 2) Identify special considerations in identifying and treating post-traumatic stress disorder (PTSD) resulting from MST.; 3) 3) Discuss adaptations in psychotherapy that are effective when working with individuals who have experienced MST as well as their families.; and 4) 4) Practice identifying unique aspects of military sexual trauma using a case vignette.

SUMMARY:

Military sexual trauma (MST) is a complex trauma that affects veterans, their families, and the community. Individuals who have experienced MST may face situations complicated by their active duty status, proximity to and reliance on their perpetrator(s), or feelings of shame and guilt. The Department of Defense has increasingly made prevention of sexual assault and providing support for victims of MST a priority. Although there is evidence that the reporting of sexual assault within the military has improved, it is estimated that 2 in 3 service members who experienced MST did not

report their sexual assault in fiscal year 2017. Reporting of MST may be avoided for several reasons, including concerns of lack of confidentiality, adverse treatment by peers, fear of retaliation, and beliefs that nothing would be done. Past data suggests the experience of MST poses a greater risk for negative mental health outcomes when compared to nonsexual combat-related trauma in the military or sexual trauma as a civilian. Veterans with a history of MST are twice as likely to receive a mental health diagnosis and also more likely to have 3 or more comorbid psychiatric conditions compared to veterans without MST. There is evidence that MST can result in post-traumatic stress disorder, major depressive disorders, substance use disorders, anxiety disorders, eating disorders, increased physical symptoms, self-harm and suicidality. Despite this, MST is oftentimes not addressed in treatment, and clinicians fail to recognize as many as 95% of cases among active duty personnel as well as veterans who have returned to civilian life. The present session will provide an overview of MST, while also addressing common misconceptions. The session will address considerations for identifying and treating psychological distress in individuals with MST. Attention will also be given to secondary traumatic stress in family members and providers, as well as strategies that can be used with secondary traumatization. Participants will discuss personal and systemic barriers to treatment, in addition to discussing current improvements being made to support this vulnerable group. Participants will be provided with a case vignette highlighting issues unique to MST and will be encouraged to discuss their personal experiences of treating patients who have experienced MST. Panelists will also engage in a Q&A session with audience members.

Speak Up: Resident Self-Advocacy as an Integral Part of the Training Experience

Chairs: Sabrina Ali, M.D., Piali S. Samanta, M.D.

Presenters: Romain R. Branch, M.D., Anita Rani Kishore, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Engaging the audience on their views of resident advocacy and creating a comprehensive definition.; 2) Identifying the current

strengths and challenges in psychiatric residency training.; 3) Recognizing the additional areas for self-advocacy that go beyond wellness and the need for an integrated approach.; 4) Understanding the critical role of program leadership in encouraging resident participation in program development.; and 5) Encouraging audience engagement in creating actionable items, plans, and resources that can be used to guide future objectives for self-advocacy in residents.

SUMMARY:

Within the medical field, advocacy has primarily been reserved for the championing of patients. Across all disciplines, residents are trained to advocate for their patients, because in doing so, they improve a variety of patient outcomes. A literature search targeting resident advocacy primarily yields research that focuses on teaching residents how to lobby at the local and national level to improve access and resources for the individuals they treat. Clinicians can be observed battling major hurdles for their patients on a regular basis, and this is equally important in psychiatry given a history of stigma and oppression towards a vulnerable population. However, there has been an inadvertent oversight in training residents on how to also advocate for themselves within this medical system. As our healthcare system evolves from a paternalistic approach, we must incorporate this paradigm shift into residency training, by thinking of residents as future colleagues and creating a more active role for them in the decision making process. The focus of this panel is to call attention to the importance of residents as proponents for their own clinical work, educational needs, wellness, and career development by engaging the audience in creating and developing an alternate definition of resident advocate. Current research and literature devoted to residency advocacy does not pay heed to this topic, and given the critical importance of advocacy, it behooves medical professionals to seek a deeper understanding. Our session will discuss the strengths and challenges psychiatric residents encounter during their four years of general psychiatry training. This perspective will be broadened by the addition of the training leadership's perspective in balancing program requirements and the desires of residents. We will conclude by demonstrating how residents

can be a change agent within their programs and advocate for their own needs. We will use examples from our own training to demonstrate these topics and encourage the audience to actively participate with examples of their own. We expect to start a discussion on this important topic in the hopes of creating national awareness about a need for training that encourages and fosters self-advocacy amongst residents.

Successful Negotiations for Women in Academic Medicine Workshop

Chair: Shannon Suo, M.D.

Presenters: Sarah Yvonne Vinson, M.D., Wetona Suzanne Eidson-Ton, Kristin Olson

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Identify your own dominant bargaining style and what styles others are using.; 2) 2. Demonstrate flexibility in response to differing bargaining styles to accomplish your goals.; and 3) 3. Describe how different negotiations are affected by relationships, politics, and creative solutions.

SUMMARY:

Women are vastly underrepresented in academic leadership at medical schools. A 2015 study found that only 38% of all full-time faculty are women, and only 15% of chairs are women (16% in psychiatry). Women in academic medicine often endorse feeling inadequately prepared for negotiation, one possible barrier/impediment to faster/further promotion. Female K-awardees have reported inadequate access to resources, thought in part due to inadequate or disadvantaged informal negotiation. This workshop will help participants identify their individual bargaining styles and learn how to adapt to the styles of others with whom they may negotiate. Participants will be asked to complete a short survey to determine their predominant style, followed by an interactive didactic about the differences between styles, and concluding with a role-play and debrief of a possible academic negotiation. Participants are encouraged to arrive on time and stay for the entire session to maximize learning. Participants are not limited by gender or only to those in academic medicine, but role-plays

and discussions will be focused on academic settings.

Sustainable Psychiatry: Solutions for Healthier Minds, Stronger Systems and Lower Emissions

Chair: Alexander Peter Schrobenhauser-Clonan, M.D., M.Sc.

Presenters: Elizabeth Haase, M.D., Peter M. Yellowlees, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn surprising truths about the carbon footprint of psychiatric services in the United States; 2) Understand and learn to use tools to calculate carbon footprints for mental health settings including clinics, inpatient units, and private practices; and 3) Evaluate the mental health and sustainability impacts of low-emission innovations such as telemedicine, active transport and pharmaceutical stewardship

SUMMARY:

Healthcare in the United States is responsible for roughly 10% of the nation's gross carbon dioxide emissions, while our healthcare system's total greenhouse gases production in the year 2013 alone has been estimated to cause between 123,000 to 381,000 disability adjusted life years (DALYs) of future health impairment amongst the very populations we intend to help. This impressive irony mandates the reduction of the carbon footprint of our healthcare system to preserve the health of the human population. The sources of greenhouse gas production in healthcare in general and psychiatry in particular may surprise the average clinician. For example, pharmaceutical production and delivery has been estimated to produce 22% of the total greenhouse gases of US healthcare, and has been identified as a "carbon hotspot" in psychiatry in particular. Our panel will introduce the sources of greenhouse gas production in various aspects of US mental healthcare delivery, and then quantify these through easily accessible carbon calculation tools that can be applied in any psychiatric practice setting. We will use didactics and audience participation to practice the application of these tools to assess carbon waste at several levels of psychiatric care. We will consider the carbon-saving

impact of sustainability-driven mental health innovations, such as applications of telemedicine, eCBT, and patient monitoring and contingency planning that allows for prompt and appropriate utilization of mental health care by patients. The panel will consider the health co-benefits of many of these sustainability measures, including decreased over-prescribing, reduction of inpatient days, and reductions in obesity and diabetes from increased active time outdoors, as well as the mental health benefits of time in nature. We will also emphasize the ethical imperative of practicing sustainable psychiatry to prevent the unequal health burden of atmospheric greenhouse gas accumulation on minority and underserved populations, including those with serious and persistent mental illness.

Telepsychiatry to Achieve the Triple Aim

Presenter: Avrim B. Fishkind, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Establish How the Triple Aim Applies to Telepsychiatry; 2) Identify the Components of Telepsychiatry That Are Accessible to Patients; 3) Understand how Telepsychiatry Can Be at The Right Place at the Right Time; and 4) Understand How To Implement Telepsychiatry Systems at the Local, State and Federal Levels

SUMMARY:

The science fiction author, Arthur C. Clarke, wrote "The only way of discovering the limits of the possible is to venture a little way past them into the impossible...and any sufficiently advanced technology is indistinguishable from magic." Mr. Clarke's laws of prediction capture the romance of telepsychiatry. The "magic" of e-mental health occurs by using teleconferencing, described in the American Telemedicine Association's Practice Guidelines for Video-Conferencing for TeleMental Health as "electronic communication between multiple users at two or more sites which facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems." Despite frequent criticism about telepsychiatry, it remains a marvel that the psychiatrist and patient can be morphed into a continuous series of zeros and ones ... zipping through cables across the world

... which are then reassembled into video and audio streams ... to create a therapeutic collaboration. In the age where people more frequently accept deep and meaningful online relationships, the acceptance of telepsychiatry steadily increases. The IHI Triple Aim is a useful tool for understanding how to create value based care in medicine. The Triple Aim provides a structure for linking Population Health, Experience of Care and Per Capita cost. With this framework, it is then incumbent on the telemedicine sphere to show how tele-health can fulfill these goals. Does telepsychiatry improve access to care? Can telepsychiatry impacts populations and not just individuals? Do patients believe that telemedicine consultations are the equivalent of face-to face interactions? Do patients refuse telemedicine services? Telemedicine is rumored to be costly ... does investing in the up front costs lead to cost savings down the line? Barriers exist in the implementation of telepsychiatry but they are gradually being eased. Issues still remain concerning using psychiatrists living overseas, prescribing of controlled substances, supervision of ANPs, and security issues and certification. Agencies such as Joint Commission, HiTrust and others are becoming major players in clinical and standards for telemedicine. Agencies such as the APA and the American Telemedicine Association have become great advocates in decreasing telemedicine barriers. There is still much work to be done at the Federal Level ... including the Telemedicine Interstate Compact. Going forward, telemedicine will be integrating with phone apps, online therapy, peer run forums, beside table devices, and wearables like watches. Psychiatrists need to stay ahead of these technologies to understand how to integrate them into their practices, similar to internists getting reports on blood pressures between visits. Eventually you can imagine doctors with data analyzers in their practice keeping up with patients between appointments based upon remote data collection. The future for telemental health is exploding with innovation.

Telepsychiatry: From Concept to Implementation

Chair: Hossam M. Mahmoud, M.D., M.P.H.

Presenters: Omar Elhaj, M.D., Snezana Cerda, Naveen Kathuria

Discussant: Bridget Mitchell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the advantages and limitations of telepsychiatry based on the evidence in the literature; 2) Appreciate the regulatory and legal frameworks of telepsychiatry practice; 3) Assess the guidelines and restrictions for prescribing controlled substance remotely; 4) Realize the opportunities and challenges of telepsychiatry implementation; and 5) Recognize the potential impact of telepsychiatry on the psychiatrist's health and well-being

SUMMARY:

Telepsychiatry has been demonstrated to be an efficient and cost-effective method of providing mental health services, with a high degree of feasibility, acceptability and satisfaction, among both psychiatrists and patients. Videoconferencing has proven particularly useful for enhancing access to care in rural areas and other under-served communities and settings, as this method of care delivery can draw from a larger national pool of psychiatrists. Over the past few years, there has been an exponential increase in the use of videoconferencing for healthcare provision, allowing more psychiatrists to serve healthcare facilities and patients across state lines. In addition, there is a push for expanding the application of telepsychiatry services, such as providing medication-assisted treatment (MAT) for opioid use disorders (OUD), consultative services and collaborative care. As telehealth implementation continues to expand, it has become necessary to widen the discussion beyond the evidence-based literature and into the complexities of implementation, such as the regulatory, practical and quality components that affect the feasibility and successful implementation of telepsychiatry services. This session aims to focus on the practical components that facilitate and - at times - restrict the implementation of telepsychiatry services. After providing a quick evidence-based review of the utility, advantages and limitations of telepsychiatry, we will discuss three practical aspects of implementation. First, we will discuss the regulatory complexities of implementation, including legislative and licensure guidelines and restrictions, cybersecurity, HIPAA compliance, the Ryan Haight

Act, prescribing controlled substances, DEA registration and the potential for providing MAT for OUD. Second, we will discuss key steps in ensuring successful implementation of telepsychiatry services from the perspective of healthcare facilities, including the technology component (hardware and software requirements), contingency planning, staff training, billing and reimbursement. Third, we will discuss the opportunities and challenges of practicing telepsychiatry from the psychiatrist's perspective, including integrating oneself into the local care team, lifestyle changes associated with videoconferencing, potential effects on well-being and burnout, and strategies for self care and professional fulfillment. Finally, the audience will be presented with three hypothetical telepsychiatry case studies for discussion: (1) managing a psychiatric crisis, (2) exploring the regulatory guidelines regarding MAT for OUD, and (3) dealing with technology breakdown.

The Impact of Technology Change on Human Behavior (and How to Evaluate It in Clinical Practice)

Chairs: Robert Kennedy, John Luo, M.D.

Presenters: Carlyle Hung-Lun Chan, M.D., Steven Richard Chan, M.D., M.B.A., John Torous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participant will be better able to understand the impact of technology on human behavior; 2) 2. At the conclusion of this session, the participant will be able to assess an individual's use of technology in their everyday life.; and 3) 3.

At the conclusion of this session, the participant will be able to describe the currently proposed diagnostic criteria for Gaming Disorder

SUMMARY:

Technology and the Internet have become an integral part of our daily lives over the last few decades. It has changed fundamental ways in which we do business, communication, educational systems, social lives, and recreational activities. In addition there are generations that have grown up using technology and educators and researchers are evaluating the impact of technology on learning,

thinking styles, relationships and approaches to problem solving. Whether part of the "digital generation" or an older generation who have learned to adapt to new technologies, there are benefits as well as liabilities associated with using technology. For some individuals, addictive behaviors have been associated with games, Internet use, and social media. DSM-5 has included Gaming Disorder in the "Conditions for Further Study" section and recently, ICD-11 has included it under the Addictive Behaviors section. However, behaviors related to the Internet and smartphone use, and social media access has changed over the last decade. What may have been considered "excessive" several years ago, is now becoming the norm according to research surveys. Clinicians need to be up-to-date on technology use and behaviors. Many clinicians do not include questions about technology use in routine history taking and mental status exams and are unaware about what questions to ask that can elicit problem behaviors. There is also a lack of awareness of the DSM or ICD-11 criteria used to determine an addiction to gaming. This workshop will review the current technologies, generational and evolving differences in managing technology, a new proposed technology component of a history and mental status as well as future directions, perspectives and recommendations.

The Importance of Psychiatric Pharmaceutical Supply Chains in Disasters

Chairs: Elspeth Cameron Ritchie, M.D., M.P.H., Kenneth E. Richter, D.O.

Presenters: Nicholas Peake, Megan Ehret

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how pharmaceutical supply chains can get disrupted in a variety of situations; 2) Know which medications have high risk of withdrawal symptoms; and 3) Learn how to ensure that the patient has an adequate supply of medications

SUMMARY:

Disasters hit the United States and the rest of the world with increasing frequency. Disaster planners focus on saving lives, electricity, clean water and other public health measures. What is not

adequately planned for is a disruption in the pharmaceutical supply chain of psychiatric medications. In major storm related events, such as Hurricane Katrina in New Orleans in 2005, the disruptions in supply chains included psychiatric medications. Withdrawal from antidepressants and benzodiazepines have their own risks, the latter being more life threatening. Therefore it is critically important that psychiatrists think about how to ensure their patients have a supply of their medications. This may imply stockpiling on a personal basis or a community one. During major disasters, patients may not have access to their medications or the medications may not be able to be fed into the healthcare system for dispersion to the patients in need. Pharmacies may be closed, medications could expire as refrigeration services may be limited, deliveries of medications may not be able to make it to an effected area, and disruption in supply chains due to the inability of manufacturing plants to manufacture medications could also occur. After Hurricane Maria, sterile water was in short supply due to manufacturing concerns. Additionally, providers may not be available to prescribe needed medications. Available providers may not be aware of a patient's medication history or they may be uncomfortable with psychiatric medications. Medications used in the treatment of behavioral health can have very severe consequences if discontinued. Patients may experience withdrawal symptoms, increased psychiatric symptoms, new psychiatric symptoms, thoughts of self-harm or harm to others, psychosis, or cravings. Without proper preparation and planning, many patients with behavioral health illnesses can be left in the most vulnerable state during a major disaster. Providers, patients, and emergency response and healthcare workers need to work together to consider and plan for major disasters to avoid a costly medication withdrawal. Patients should refill medications prior to a disaster and maintain a personal stockpile of medications if insurance and provider allows. Emergency kits should be prepared by the patient to quickly grab and go if needed. Additionally, patients should carry a current list of medications. Providers should develop emergency plans for all medications including buprenorphine, long acting injectables, benzodiazepines, and opioids. Additionally, considerations for those medications requiring more

intensive monitoring, lithium and clozapine, should be documented and discussed with the patient. Providers should verify patients have list of current medications. Treatment plans should include thoughts and discussions regarding contingency planning for disasters, particularly in those regions most likely to be effected.

The Multiple Faces of Deportation: Being a Solution to the Challenges Faced by Asylum Seekers, Mixed Status Families, and Dreamers

Chair: Maria C. Zerrate, M.D., M.H.S.

Presenters: Annie Sze Yan Li, M.D., Gabrielle L. Shapiro, M.D., Caitlin Rose Costello, M.D., Suzan Song, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be better able to understand the psychosocial stressors and needs of children and families undergoing different immigration proceedings.; 2) Participants will be able to identify steps towards becoming an advocate or creating programs to support these vulnerable populations.; and 3) Participants will acquire a basic understanding of legal proceedings immigrant children and their families face.

SUMMARY:

Asylum seekers, dreamers, and children from mixed status families are part of the growing underserved minority and immigrant populations in the USA, who are in dire need of adequate mental health care. Under the current political climate, increased attention is being paid to the psychosocial needs of youth and their families facing significant stress related to their own immigration status or their parents' status (Shidu 2017). In this talk, presenters will impart fundamental information on the status and challenges faced by youth under The Deferred Action for Childhood Arrival, asylum seekers, unaccompanied minors, families separated at the border, and children from mixed status families. We will highlight the efforts led by child and adolescent psychiatrists providing care and/or advocating for these youth and their families. We will present relevant legal information that can help mental health providers assist youth, and families in understanding their situations and seek out

appropriate supports. Dr. Annie Li will present an overview on youth referred to as DREAMers, and will share her unique personal account of being an undocumented youth highlighting the challenges faced by this group. She will also talk about the impact of the Deferred Action on Childhood Removal on this particular immigrant group. Dr. Suzan Song will provide a comprehensive review on the assessment of unaccompanied minors from a risk-resiliency model, and will discuss the most recent crisis of families separated at the border when trying to seek asylum highlighting the complex interplay between cultural constructs, the drivers and determinants of migration and the long journey between fleeing their home country, and rebuilding their lives after entering the US (Carson 2012). Dr. Caitlin Costello will provide an overview of the legislation and policy changes that directly affect unaccompanied minors and mixed-status families. She will highlight how unaccompanied minors often go through immigration proceedings without the right representation and how they may not be able to access different forms of immigration relief. These legal complications compound with the underlying challenges of forced migration, trauma, cultural stress and acculturation. The presentations will be followed by a discussion by Dr. Gabriel Shapiro M.D., who will provide further considerations on the assessment, treatment, legal complexities, and advocacy efforts to support these vulnerable populations. Asylum seekers, dreamers, and children from mixed status families are vulnerable populations in need of comprehensive care and supports; and psychiatrists have a critical role in advancing treatment, redefining service delivery, and informing local and national policy for these youth and their families living in fear of deportatio

The Opioid Crisis: Implementation of the Medication First Approach for Opioid Use Disorder (OUD) and Its Impact

Chair: Angeline A. Stanislaus, M.D.

Presenter: Roopa Sethi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • Understand the key components of the Medication First approach to treat Opioid Use Disorder (OUD); 2) •

Recognize the challenges in implementing the Medication First approach for OUD; and 3) •

Learn effective strategies in working through the barriers, and its positive impact in bringing system wide change

SUMMARY:

Opioid overdoses kill more people today than automobile related accidents. In 2017, 72,000 Americans died of a drug overdose (CDC data), most of those due to opioids. Nationwide, the rate of drug overdose deaths involving opioids increased on average by 19% per year between 2013 and 2016 (CDC data). Missouri saw a 35% increase in opioid overdose deaths from 2015 to 2016. In 2017, Missouri became a recipient of the Federal Opioid State Targeted Response (STR) Grant with \$10 million a year for two years. This allowed Missouri to address the opioid overdose death crisis by implementing some statewide strategies. Moving towards a Medication First approach to treat Opioid Use Disorders (OUD) is one of them. Medication First approach advocates for a low-barrier to access FDA approved medications for the treatment of OUD, namely office-based prescription of buprenorphine for treatment of acute withdrawal symptoms and continued maintenance treatment of OUD, if appropriate, at our state contracted substance abuse treatment centers. It does not mean medication only treatment. Individualized psychosocial services are added once the patient is stabilized on medications. Research data shows that prescription of opioid agonist (methadone) and opioid partial-agonist (buprenorphine) early in treatment decreases opioid withdrawal related distress, improves retention in treatment, improves treatment outcomes and thereby, decreases illicit opioid overdose deaths. We faced several challenges in implementing this model. Some of the challenges we faced were: • Lack of DATA 2000 Waivered physicians in the state • Changing the paradigm of thinking about OUD from a self-inflicted moral failing to that of a chronic disease model of care • Getting buy-in from established substance use treatment providers • The concept of substituting one opioid for another was seen as irrational • Re-defining treatment success from abstinence to that of improved functioning • Making this model financially feasible for the treatment providers The two

speakers of this session are psychiatrists who were involved in the project from its conception to its implementation. In this presentation, the speakers will discuss the rationale behind the Medication First approach to treatment of OUD with empirical data, and the challenges faced in implementing this model of care. They will also discuss outcome data from year one of implementing this model of care.

The Power of Technology to Enhance Collaborative Care Programs: Addressing Implementation Challenges

Chair: Bibhav Acharya, M.D.

Presenters: Lydia A. Chwastiak, M.D., M.P.H., Amy M. Bauer, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify opportunities to integrate technology into collaborative care programs to increase reach or effectiveness.; 2) Learn how technology can be used to support the core principles of collaborative care; and 3) Understand how challenges to implementation of technology interventions were addressed in clinical collaborative care programs

SUMMARY:

In low-resource settings, technological tools such as phone consultations and electronic decision-support tools, can leverage psychiatric expertise to support front-line healthcare workers. In contrast to robust evidence for the effectiveness of collaborative care for the treatment of depression, recent studies that incorporated technological tools (e.g., teleconsultation) have had mixed results. Specific challenges must be addressed to leverage technological innovations to improve efficiency and reach of psychiatric care. This session will describe challenges and strategies in implementing three widely-used technological tools (teleconsultation, mobile health platforms and electronic decision-support) in low-resource settings. The Integrating Depression and Diabetes Treatment (INDEPENDENT) trial tests the effectiveness of a multi-component care model for individuals (n=404) with poorly-controlled diabetes and depression in four diabetes clinics in India. The INDEPENDENT intervention

combines collaborative care, decision-support, and population health management. A Decision Support-Electronic Health Record (DS-EHR) system to support population health management was provided to each participating clinic. The DS-EHR: (1) displayed consultation and laboratory data in a single platform; (2) had a clinic-level dashboard to assist in prioritizing participants for follow-up; (3) provided visualization tools at the clinic and individual participant levels to monitor trends in clinical indicators over time and individualized clinical care prompts for glucose, blood pressure, lipid and depression management. The Nepal CoCM study was implemented in a rural primary care clinic where over 2000 patients received care from 20 primary care providers and 2 counselors with a psychiatrist conducting teleconsultations. Preliminary analysis shows that 47% of patients with depression achieved clinical response (PHQ-9 = 50% of baseline). Common challenges for successful implementation of teleconsultation that will be presented in this session include: poor mental health competencies and high turnover among primary care providers; need for urgent consultations; psychiatrist discomfort with lack of direct patient contact; unreliable electricity, technological tools, documentation, and delivery of treatment recommendations; on-site clinicians' low motivation to accept psychiatrist recommendations; and mismatch between the psychiatrist's recommendations and the site's capacity to implement them. To date, technologies to support collaborative care typically have consisted of clinician-facing tools. Because Collaborative Care is a patient-centered approach that seeks to inform and activate patients to improve self-management, the use of a patient-facing mobile tool is a logical extension of the model. Dr. Bauer will describe the development of a mobile health platform to support collaborative care and its feasibility and acceptability in a clinical setting.

The Prescription for Wellness: Positive Psychiatry Interventions

Chairs: Helen Lavretsky, M.D., Ellen Eun-Ok Lee, M.D.

Presenter: Carl Compton Bell, M.D.

Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the session's end, participants will be able to describe the prevalence of fetal alcohol exposure (FAE) in various countries/contexts and its psychiatric presentation in child and adulthood.; 2) At the conclusion of this session, participants will be able to implement biotechnical prevention strategies to ameliorate some of the problems caused by FAE.; 3) At the conclusion of this session, participants will be able to adopt psychosocial interventions for resilience in older adults into their clinical practice.; 4) At the conclusion of this session, participants will be able to utilize mind-body interventions for treatment and prevention of mood and cognitive disorders of aging.; and 5) At the conclusion of this session, participants will be able to describe how yoga may affect verbal memory through the default mode network.

SUMMARY:

Positive psychiatry is the practice of promoting well-being by enhancing positive psychosocial factors among people with mental and physical illnesses. While current psychiatric medications and interventions are focused on correcting problems like depression and psychosis, there is growing interest in positive psychiatric interventions to go beyond curing problems and promote wellness and improve quality of life (Jeste and Palmer, 2015). This unique and interaction symposium will highlight a number of positive psychiatric interventions including preventative strategies, psychosocial interventions and mind-body interventions. Carl Bell, MD, will highlight the prevalence and downstream consequences for alcohol exposure (FAE), a problem with disproportionately high prevalence in non-white communities (O'Connell et al., 2009). Dr. Bell will then discuss preventative strategies for FAE. Ellen Lee, MD will describe the concept of resilience as well as review the literature on resilience interventions and their efficacy in persons with and without mental illnesses (Lee et al., 2018). Dr. Lee will describe the development of a psychosocial intervention to increase resilience in adults living in independent living facilities and discuss the main findings. Helen Lavretsky, MD, MS will review the evidence of efficacy and application of mind-body interventions, e.g., meditation, tai chi, qi-gong and

yoga, for a broad range of stress-related neuropsychiatric disorders (Eyre et al., 2016). Dr. Lavretsky will also discuss potential neurobiological mechanisms of these interventions and present new data from recent trials of Kundalini Yoga and Tai Chi for late-life mood and cognitive disorders. Dilip Jeste, MD will moderate and lead a discussion of the use of positive psychiatry prevention and intervention strategies in clinical practice. This proposed symposium is consistent with the 2019 APA Annual Meeting theme, "Revitalize Psychiatry: Disrupt, Include, Engage, and Innovate" as this session will discuss new, empirical interventions that adopt a unique approach to improving wellness for patients. The panel of speakers spans three different institutions and includes one Resident-Fellow Member (Dr. Lee).

To Treat or Not to Treat: Is That the Question? The Evaluation and Treatment of Mood Disorders in Case Examples of Pregnant Women

Chair: Kara E. Driscoll, M.D.

Presenters: Jennifer Marie Sprague, M.D., Hannah Karine Betcher, M.D.

Discussant: Crystal T. Clark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) RECOGNIZE THE BARRIERS TO THE IDENTIFICATION AND TREATMENT OF MOOD DISORDERS DURING PREGNANCY; 2) ENGAGE A PATIENT IN DISCUSSION AND DECISION-MAKING REGARDING HER TREATMENT; 3) HIGHLIGHT THE AVAILABLE DATA ON THE USE OF ANTIPSYCHOTICS IN PERINATAL MOOD DISORDERS; and 4) DELIVER EVIDENCE-BASED PSYCHIATRIC CARE TO THIS VULNERABLE AND IMPORTANT POPULATION

SUMMARY:

Women are particularly vulnerable to the occurrence of mood episodes during the childbearing years. In spite of this, identification of mood disturbance is often delayed and undertreated during pregnancy, particularly as compared to non-pregnant women. As a result, there is a risk of relapse of prior illness or unnecessary prolongation of the identification and treatment of new illness during pregnancy which impacts both mother and her child. Many mental health practitioners and patients feel overwhelmed

by the decision-making involved in the care of a pregnant woman with mood disturbance. This workshop is designed to 1) highlight and address some of the barriers to identification and treatment of mood disorders during pregnancy and 2) facilitate better care of the pregnant patient. Attendees will participate in discussion of case examples of pregnant women with mood disorders, focusing on evaluation, treatment options (especially the use of antipsychotics), and common dilemmas. The workshop leaders and attendees will collaborate in creating an individual treatment plan for each patient. The workshop will highlight common screening tools, risks of treatment versus no treatment, possible exposures during pregnancy, and potential for relapse in those with a history of mood disorders. Workshop leaders and participants will also discuss issues of medication monitoring and dose adjustments secondary to pregnancy metabolism and as well as planning for the postpartum period. Finally, the participants will practice skills for engaging the patient in a discussion about treatment and fostering patient participation in the decision-making. Workshop presenters will incorporate current evidence available for the treatment of mood disorders during pregnancy. At the end of this workshop, the participants will have increased comfort with the individualized evaluation, identification, and treatment of mood disorders in pregnant women.

Transgender Care: How Psychiatrists Can Decrease Barriers and Provide Gender-Affirming Care

Chair: Cassy Friedrich, M.D.

Presenter: Tamar C. Carmel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand that classification of gender-nonconforming identities as pathology creates barriers to care and can lead to re-traumatization to a stigmatized and marginalized population; 2) Understand what the informed consent model is and that it is recognized as an appropriate model of care for people seeking gender-affirming hormones; 3) Provide mental health clearance letter to gender non-conforming people in an affirming and supportive manner; and 4) Identify the roles psychiatrists can play to improve

mental health outcomes for gender non-conforming people

SUMMARY:

In June 2018, the WHO announced its decision to depathologize transgender and gender non-conforming (GNC) identities in ICD-11 by classifying them as gender incongruence in the category sexual health conditions rather than classifying them as mental disorders. This move was made due to recognition that classifying trans/GNC identities as a mental disorder is stigmatizing, but the need for a code remains as trans/GNC people do have significant health care needs and therefore some medical coding is needed. However, insurance providers in the United States typically require that trans/GNC people obtain mental health clearance letters from mental health providers such as psychiatrists prior to getting coverage for getting gender-affirming surgeries and, in some places, prior to getting hormone prescriptions. This model of care creates additional barriers to these treatments which improve mental health outcomes in a population that already faces multiple other barriers to care. An alternative and increasingly utilized model for providing gender-affirming care is the informed consent model in which providers of gender-affirming treatments themselves directly assess the patients' ability to provide informed consent without referral to mental health for one or more required clearance letters. Because insurance companies continue to classify trans/GNC identities as mental disorders and therefore often will not cover gender affirming treatments without mental health clearance letters, it is important that psychiatrists understand how to provide affirming and supportive consultations for their trans/GNC patients seeking clearance letters. This includes understanding and internalizing that trans/GNC is not pathology and readily knowing how to write clearance letters to make this required step less challenging for patients. Additionally, psychiatrists can best serve their trans/GNC patients by having awareness of the health disparities they experience, understanding the minority stress model, understanding that each patient has individual goals for their gender transition, and by using a trauma-informed approaches in their encounters. Psychiatrists do not typically receive training on

providing affirming and supportive care for their trans/GNC patients, so this session is designed to help prepare psychiatrists to provide affirming care for their trans/GNC patients. In this workshop, we will have a didactic portion in which we review with a review of the use of pronouns and taking a gender history followed by a discussion of the history of the pathologization gender identity, and the informed consent model. We will then break into small groups to 1) demonstrate an affirming clinical encounter with a GNC patient and discuss methods for providing gender-affirming psychiatric care and 2) practice writing a typical mental health clearance letter based on a case vignette.

Transitioning From Methadone to Buprenorphine at an Urban Opioid Treatment Program

Chair: Timothy K. Brennan, M.D., M.P.H.

Presenters: Annie Levesque, M.D., Prameet Singh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the unique challenges of methadone maintenance; 2) Describe the rationale in transitioning from methadone to buprenorphine maintenance; and 3) Demonstrate the clinical process of transitioning from methadone to buprenorphine maintenance

SUMMARY:

The gold standard treatment for opioid use disorder is opioid agonist treatment with either methadone or buprenorphine maintenance therapy. Decades of experience in the treatment of opioid use disorder have proven that patients are at far less risk overdose after enrolling on opioid agonist treatment. While multiple published studies have demonstrated that methadone and buprenorphine are similarly effective to reduce opioid use in patients with opioid use disorder, there are significant drawbacks to methadone maintenance treatment. - Methadone is associated with greater risks of side-effects compared with buprenorphine treatment - Patients harbor long-standing suspicions about the side-effects of methadone (even those that are not based in science) - Patients must wait significant periods of time before earning “take home” dose privileges - Methadone has a greater

overdose risk than buprenorphine This session will focus on the experience of transitioning methadone maintenance patients onto direct-observed buprenorphine at a busy, urban, hospital-based opioid treatment program, specifically the Opioid Treatment Program at Mt. Sinai West Hospital in New York City. The transition process from methadone to buprenorphine will be reviewed and clinical pearls and experience-based pitfalls will be examined.

What Should the APA Do About Climate Change?

Chair: David Alan Pollack, M.D.

Presenters: Ayana Jordan, M.D., Ph.D., Rahn K. Bailey, M.D.

Discussants: Eliot Sorel, M.D., Robin Julia Cooper, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The learner will gain a clear understanding of the imminent and critical risks to general, mental, and public health posed by climate change.; 2) The learner will recognize the validity of the ethical obligation to warn others of the relevant health risks and remedies associated with climate change.; 3) The learner will understand, endorse, and be motivated to participate in efforts to educate colleagues, trainees, and the general public regarding the mental health aspects of climate change.; and 4) The learner will become familiar with the concept of Transformational Resilience as a valid public health intervention to assist communities to prepare for CC and to remain healthy.

SUMMARY:

Abundant evidence exists demonstrating that Climate Change (CC) is real, immediate, and catastrophically severe in its anticipated outcomes. More disturbing is the fact that sufficient information was known 40-50 years ago to spur more progressive action that could have averted the disastrous state that the earth is now experiencing and expecting. Denial has dominated policy, political, and economic decisions and action at cultural and economic levels throughout the nations of the earth, but more currently and distressingly in the United States. Unless and until the world awakens to this

reality and its implications for the health and mental health of individuals and communities throughout the earth, the worst can be expected. The questions for this forum of leaders of the APA and climate psychiatry experts revolve around the roles and responsibilities of organized psychiatry to participate in efforts to: • Address denial by warning the public and health communities of the severity and immediacy of CC, • Educate our colleagues regarding the kinds of psychiatric conditions that may arise or become more prevalent and evidence-supported interventions to address them, • Research the psychiatric conditions most affected by or originating from CC and its multiple, interrelated impacts, as well as the most promising methods for treatment. • Assist communities in the ongoing efforts to prepare for, mitigate, reverse, and prevent the impacts of CC, while supporting them and the individuals and families within them to maintain and improve their health, mental health and sense of community. These are essential elements of the ongoing maintenance of public health in the near and indeterminant future. • Advocate for sane policies to address the most significant sources of excess carbon in the atmosphere, namely fossil fuels and large scale animal agriculture. • Promote positive contributory behavior to carbon footprint reductions from within the psychiatric and broader health community. This includes “greening” individual, clinical practice, hospital and larger organizational levels of operations.

Working Clinically With Eco-Anxiety in the Age of Climate Change: What Do We Know and What Can We Do?

Chairs: Elizabeth Haase, M.D., Janet Lisa Lewis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn the reported clinical syndromes associated with climate anxiety; 2) Consider existing psychiatric models, including complicated bereavement and chronic traumatic stress, for conceptualizing climate anxiety and working with it clinically; 3) Identify signs of eco-anxiety associated with negative clinical outcomes including suicide; 4) Understand the uses and limitations of existing anxiety disorder treatments for anxiety associated with existential, real, or

chronic climate threat; and 5) Learn how to incorporate Ecotherapy treatments into evidence-based psychiatric practice

SUMMARY:

Climate change has been called the greatest health threat of the 21st Century. A vital arena for psychiatry’s engagement with this threat is to understand and treat the distress it causes. Some of this clinical distress includes increasing rates of suicide among those in climates with hotter temperatures and droughts and traumatic stress disorders after disasters. Other forms of climate distress are also being described, as individuals seek to cope with their awareness of future climate dangers. The existential nature of climate anxiety and its remoteness from the individual’s locus of control poses particular psychic challenges that may lead patients to disabling obsessive rumination, compulsions, displacements and dissociation of climate concern from lifestyle and action. Additionally, climate-based worries that may not be overtly symptomatic have been shown in recent studies to be significant for up to sixty percent of the general United States population, and clinicians are being called upon to respond to such prevalent worry. The threats posed by climate change may pose particular issues for young adults, for those who have children or grandchildren, and for patients with histories of abuse and neglect. Existing anxiety treatments, often based on minimizing fears and behaviors associated with amygdalar hyper-reactivity, are not designed to respond to real current threats. Treatment of anxiety in the acute setting of natural disaster or human trauma is also geared to reduction of distress without addressing personal adaptation to new realities and real dangers. Ecoanxiety challenges clinicians to innovate new models of anxiety management in this setting. Our panel will review studies on the types of eco-anxiety, their level of clinical impact, and disabling and adaptive responses demonstrated to date. As research in this area is limited, we will introduce ways to conceptualize eco-anxiety that align with existing models for working with disorders of repeated or prolonged traumatic loss, including chronic traumatic stress disorder, complicated bereavement, and palliative care. We will review the neurobiology of anxiety due to real and present

threat versus that of anxiety disorders, and how available anxiety treatments may theoretically improve or worsen climate anxiety symptoms. Countertransference pitfalls and ways in which climate anxiety illuminates other patient issues will also be discussed. We will present recent population-based and individual case studies of climate distress as well as video clips with simulated patients illustrating the addressing of ecoanxiety. Discussion will focus on how to promote adaptive responses to habitual climate worry, including the incorporation of ecotherapy, and how to mitigate negative outcomes associated with climate despair, such as hopelessness, apathy, and self-harm.

“Yer a Psychiatrist, Harry!”: Learning Psychiatric Concepts Through the Fictional Worlds of Game of Thrones and Harry Potter

Chair: Matthew Richter

Presenters: Shruti Mutalik, Kyle J. Gray, M.D., John F. Chaves, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Disrupt traditional views of learning by demonstrating how popular culture references can be a catalyst for learning psychological concepts; 2) Discover ways to convey advanced psychological concepts to patients and trainees in a matter that is both fun and relatable.; 3) Inspire novel connections between favorite cultural experiences and professional knowledge base; and 4) Ignite passion for teaching by leveraging love of a favorite story

SUMMARY:

If you have ever found yourself lost in a good book, you know the power of great fiction to create rich neuronal landscapes. Your brain has already done the hard work of encoding an entire make-believe world, so why not leverage that synaptic real estate to more effectively learn psychotherapeutic theories and techniques? This method of learning has been shown to be “sticky” -- new knowledge is layered into familiar stories, making it easier to recollect throughout our lives. In this workshop we show how unlikely juxtapositions between popular fantasy fiction and psychological concepts can make learning not only more fun, but more successful. The first

presenter delves into the popular book and TV series ‘Game of Thrones,’ with an emphasis on how themes from the first book echo different stages of moral reasoning according to Kohlberg’s theory. These concepts are then transferred from the fictional to the practical with a case example of military combat and sexual trauma, and how this patient faced similar themes in her recovery. Our second presenter shares her story of how the more she trained in cognitive behavioral therapy, the more she started to feel like a teacher at Hogwarts. Starting with the use of the “riddikulus” spell on a boggart, she demonstrates how several aspects of the Harry Potter story parallel our efforts as therapists. She was able to use these metaphors to connect with an adolescent patient facing medical phobias. After exploring these themes through both fiction and case studies, we strive to engage the audience in this creative process. Using a small group format, we aim to tap into the passion within audience members for other artistic expressions, and help them to connect it to psychiatric concepts, forging yet more synaptic buds in real time. We will prime audience members with a variety of potential topics to explore, prompting rich discussion and innovation...and a good bit of fun.

You’ve Been Subpoenaed. Keep Calm—Here’s How to Testify Like an Expert

Chair: Ashley VanDercar, M.D., J.D.

Presenters: Ashley VanDercar, M.D., J.D., Stephen G. Noffsinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the reasons psychiatrists are subpoenaed; 2) Recognize the dynamics between a witness and the rest of the court: judge, jury, attorneys; 3) Understand the importance of the witnesses’ role (either as a defendant, fact-witness, or expert witness) as a storyteller and educator; and 4) Utilize techniques to improve effectiveness on the witness stand

SUMMARY:

There are many reasons psychiatrists are subpoenaed. The case might directly involve the psychiatrist, such as a malpractice action ... or, it might be a civil or criminal case about one of their

patients. In any of these situations – unlike the expert witness – the subpoenaed psychiatrist does not really want to testify. It is scary and overwhelming. And, if it is a malpractice case, the professional and personal ramifications can be huge. A subpoena often starts with a deposition, then sometimes a court hearing or trial. The dynamics in each setting are different. We will focus on hearings and trials, evaluating the nature of the interactions between the (psychiatrist) witness and the rest of the court – especially the finder of fact (judge or jury) and subpoenaing attorney. Given the high-stakes associated with testifying, it is important to be well prepared. Not just with the content, but the presentation. This session will provide some basic information on the courtroom “rules” witnesses need to know: ranging from decorum to attire. The session also describe the witnesses’ role, the importance of being a storyteller, and the need to provide educational context with psychiatric testimony (aka: the need to be an educator). A number of specific techniques for effective testifying will be described. At the end of the session a panel of volunteers will be chosen from the audience and given an opportunity to answer questions under direct and cross-examination. Audience members will then provide critiques, and speakers will provide insights on possible improvements that the volunteers could have made with their response techniques.

Youth Online Presence: The Clinician’s Approach to Educating Patients About Risks and the Law

Chair: Paul Mark Elizondo, D.O.

Presenters: Caitlin Rose Costello, M.D., Gabrielle L. Shapiro, M.D., Swathi Krishna, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe several forms of risky online activities in which youth engage and provide information about prevalence trends.; 2) Help clinicians understand the law that outlines privacy, parental liability, and criminal responsibility associated with youths’ social media activity.; 3) Define specific risky behaviors associated with youth social media use, including cyberstalking, cyberharassment, cyberbullying and sexting.; 4) Provide clinicians with evidence-based modalities for

helping patients’ parents safely navigate and monitor their children’s risk-taking online.; and 5) Propose directions for future research to aid our professional community with our work with families who must distinguish between appropriate use of online platforms and risky online activity.

SUMMARY:

In recent years, adolescents have become increasingly invested in social media and online activities. The rapid adoption of social media outlets such as Facebook, Instagram, Snapchat and Twitter by underage users have exposed a vulnerable population to a variety of legal, personal, social and mental health consequences. According to recent research, 92% of teens report daily online activity (1), 24% of these individuals report they are online “almost constantly” usually using more than one social networking site and sharing copious personal information including full names, ages, personal photographs, home addresses, school locations and social calendars. Communicating and sharing personal information online exposes adolescents to many risks including cyberbullying, legal consequences from sexting, exposure to online predators and exposing information to unintended audiences which could impact their plans for the future (2). Furthermore, the increase in online activity and online bullying has become a looming safety concern in this population. Negative online exposure can have detrimental effects on the physical and mental health of teenagers causing depression, anxiety, increased suicidal thoughts and even reports of completed teen suicide in some cases. This workshop will highlight the vulnerabilities of this at-risk population of underage online users and help identify “warning signs” that may signify that patients need intervention and support. Increases in online activity and social media use also have widespread legal ramifications in the adolescent population that teens, their families and providers may be unaware of. Although adolescents under the age of 18 are neither recognized in the law as adults, nor understood in psychiatry to have the fully developed capacity of adults, they easily enter into online contracts to be able to use social media (2). In our workshop, we will highlight the legal protections, or lack thereof, of underage online activity. This is an area of ongoing legal debate and

has been the subject of several recent court cases that will be highlighted and discussed by our workshop presenters. With insufficient legal protection for adolescents posting online, protecting teens from the risks of immature online decision-making often falls to outside adults. Mental health providers have a unique perspective into activities of their underage patients and may be able to provide them with education and warnings about the dangers of online activity. Our goal is to provide insight and information that can be used to engage teen patients in discussions about protecting themselves from the consequences of risky online behavior and provide information to assist mental health providers on how to approach these sensitive topics with their patients and their families.

Monday, May 20, 2019

#MeToo in Psychiatry Training: Managing Sexual Harassment From Patients

Chair: Maya Smolarek, M.D.

Presenters: Erika L. Nurmi, M.D., Ph.D., Larissa J. Mooney, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the concept of contrapower harassment as it relates to physicians; 2) Appreciate the breadth and cultural context of the problem of sexual harassment by patients; 3) Recognize instances of gendered-harassment from patients; 4) Empower and guide trainees in effective responses to sexual harassment by patients; and 5) Encourage faculty to model appropriate responses for trainees

SUMMARY:

The recent #MeToo cultural movement has awakened the public to the pervasive reality of sexual misconduct throughout multiple industries. While there has been much attention on entertainment and corporate environments, the discussion within medicine has been scant and limited to well-trodden themes of protecting patients from physicians. We are interested in exploring the unique scenarios in which physicians, holding formal positions of power, experience gendered and sexual harassment from their own

patients. We hope to develop a nuanced discussion of the context in which this occurs, the ambiguity and confusion it engenders, and the implications for the doctor, the patient, and their relationship. After laying a groundwork of cultural context for this topic, we will build a foundation of knowledge about gender and sexual harassment using real-world examples. Participants will be introduced to the notion of contrapower harassment and its particular manifestation in medicine. We will review the small amount of literature on the topic, specifically providing prevalence data estimating the extent of this problem within medicine and underscoring the lack of practical recommendations to address it. Next, we will share our own experience bringing these discussions to medical students and psychiatry residents at UCLA, which have highlighted the absence of education and sparse support trainees receive from faculty around this issue. Response from trainees has been overwhelmingly positive, with wide and enthusiastic engagement in discussion. In order to prompt audience involvement, vignettes illustrating physician harassment by patients will be presented and the audience will be encouraged to contribute by answering polls, sharing their own experiences and challenges, and engaging in group discussion. We will highlight ambiguous cases and situations that might call for different types of responses. The session will emphasize exploration and development of teachable interventions for instances of harassment by patients and how faculty and colleagues might support trainees given their uniquely vulnerable positions. The speakers will include a female resident in psychiatry and two female psychiatry attendings with experience in managing harassment and facilitating discussions with medical trainees. Our experiences at our own institution have convinced us of the importance of addressing this issue broadly and inspired us to expand these discussions to a national audience.

#SoMePsych: Using Social Media to Motivate, Engage, Disrupt, Include/Innovate, Advocate for Psychiatry

Chair: Abhisek Chandan Khandai, M.D., M.S.

Presenters: Jessica A. Gold, M.D., M.S., Laura J. Pientka, D.O., Diana M. Robinson, M.D., Christina M. Girgis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand fundamental functionality and terminology of social media platforms, particularly Facebook and Twitter; 2) Appreciate the professional and personal value of developing a social media presence and network via social media; and 3) Develop ways to advocate for psychiatry and patients via Facebook and Twitter

SUMMARY:

Today, nearly seventy percent of Americans use social media, an exponential increase from five percent in 2005 (1). More than two thirds of Americans use Facebook alone, while one in four use Twitter. As more people use social media to communicate and network with each other, there are more reasons than ever for physicians to learn how to utilize these platforms on behalf of themselves, their field, and their patient population. Although many trainees and early career psychiatrists have grown up with a familiarity with technology and the internet, it can be hard to know where to start or how and why to participate in it. Even if they decide to participate, psychiatrists at all stages of their careers are unsure of terminology, how to grow their social media presence, or how to effectively use social media to make their voices heard. And, despite a growing social media presence for physicians and medicine in general (2,3), psychiatrists still remain outside the leading voices and #hashtags, possibly due to heightened concerns about personal and patient privacy. However, understanding how and why to grow psychiatry's online presence is necessary for revitalizing the field. These concepts highlight this year's meeting theme by providing an outlet to empower attendees to be able to disrupt, include, engage, and innovate psychiatry. This workshop will address these issues and teach applicable skills to a broad range of psychiatrists. For audience members who have little or no prior experience using social media, we will start with a brief overview of relevant terminology and functionality, as well as ethical/legal issues, focusing on two of the most widely used platforms, Facebook and Twitter. Next, we will teach attendees how to grow their social media presence and develop their professional voice, as well as use social

media to promote their own academic and professional work. Then, in small groups we will discuss how to turn psychiatric news topics into effective social media posts, while sharing example tweets from psychiatrists and delineating our own personal comfort levels and boundaries on social media. Finally, through case presentations by Dr. Jessica Gold on Women in Medicine (Twitter) and Dr. Christina Girgis on Psychiatry Network (Facebook), we will discuss how to harness social media for psychiatry, while showcasing the interactive potential of social media through building our own hashtag- #SoMePsych- and entertaining audience questions also via Facebook Live and Twitter.

A Baby With a Brain and a Caregiver: Infant Mental Health Training in High-Risk Populations

Chair: Alexandra M. Harrison, M.D.

Presenters: Muhammad Zeshan, M.D., Alayne Stieglitz, M.Ed., Abishek Bala, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain and review importance of preventive intervention to support mental health in infancy (IMH), especially in high-risk populations; 2) Describe IMH training, "Protect, Nurture, and Enjoy" (PNE), explain process of using PNE in collaboration with local organization; and 3) Teach and practice the creation of "nudges" to maintain gains of training in participants

SUMMARY:

Genetic and environmental factors contribute to the etiology of psychiatric disorders throughout the life cycle. Environmental stress has been shown to play a major role in the development of the early nervous system. The infant-parent relationship has also been shown to protect against the adverse effects of environmental risk factors. It follows that interventions designed to support the infant-parent relationship during the perinatal period would be expected to promote the healthy development of individuals in a society. Despite these findings, training in IMH is rare, especially in populations where the risk is greatest. Our session will describe the creation of IMH training (PNE) by SCC, in collaboration with local institutions in high-risk populations with different cultural backgrounds.

Videotapes of aspects of the PNE will be shown, and a study of the efficacy of the PNE in India will be presented. The importance of social media “nudges” designed to sustain the training of PNE graduates will also be explained. In a discussion with SCC team members, participants will be invited to consider the potential of infant mental health training as a means of preventing mental health disorders, to consider the importance of taking into account cultural factors and collaborating with local institutions in designing mental health interventions, and to consider how innovative social media interventions can support the sustainability of this training.

A Blueprint for Providing Free, Comprehensive, Integrated Adolescent Health, Transgender Services and Mental Health Care in NYC for \$1,000 Per Patient

Chair: Kashmira Rustomji, M.D., M.P.H.

Presenter: Kashmira Rustomji, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide a rationale for the value of adolescent health care; 2) Learn service principles that guide our model of care; 3) Obtain practical knowledge on operating principles of our system of care; 4) Learn about caring for transgender youth within an integrated model; and 5) Understand the finances of a free health home and implement services in a cost effective manner

SUMMARY:

Since 1968 the Adolescent Health Care Center in New York City has been providing free, comprehensive health and mental health care for youth. The workshop will focus on principles that guide the design and operation of a system of care that appeals to youth and encourages them to seek care. You will learn practical knowledge on how 10,000 young people every year, regardless of their ability to pay or their insurance status are provided with confidential, comprehensive, integrated medical, transgender care, reproductive health, dental, optical care, behavioral and mental health. You will gain perspective on how prevention and support services are provided by a team of compassionate and competent practitioners with expertise in working with young people. You will gain

additional knowledge of the financial structure of our institution and how costs are contained while delivering high quality care to our youth. We will engage in discussions about how to implement our model in various health care settings. Through case examples you will learn about an integrated model for meeting the mental health needs of transgender and gender non-conforming youth. We will provide a guide on comprehensive, integrated and gender affirming care with an emphasis on reducing mental health disparities in this cohort.

Accountable Care Organizations in 2019: Where Does Mental Health Fit in?

Chairs: Nicole M. Benson, M.D., Andrew David Carlo, M.D.

Presenters: Trina E. Chang, M.D., M.P.H., Brent P. Forester, M.D., Jurgen Unutzer, M.D., M.A., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the key components of accountable care organizations (ACOs) and how they fit into the larger landscape of alternate payments models (APMs) for health care services.; 2) Understand the results of investigations evaluating the impact of ACOs on mental health care.; 3) Recognize how organizations plan and manage mental health care services in anticipation of ACO contracts.; 4) Recognize the experiences of systems and clinicians as mental health practices are modified in the context of ACO implementation.; and 5) Provide strategies for mental health clinicians and administrations to manage practice change associated with ACO implementation.

SUMMARY:

Accountable care organizations (ACOs) join together clinicians, health care systems, and payers with the common goal of providing coordinated, high-quality care to a defined patient population. By shifting cost and profit measurement from the individual to the population level, ACOs aim to incentivize patient-centered care that transcends traditional department- and specialty-defined silos. Unfortunately, the literature suggests that the impact of early ACOs on measurable mental health outcomes has been modest. In some studies, this finding has been attributed to the lack of mental-

health focused target or quality measures, which, in turn, has provided minimal incentive for meaningful practice change. On the other hand, one recent study demonstrated slight improvement in antidepressant adherence rates for patients treated within an ACO. Despite these overall modest findings, it is becoming increasingly apparent that the implementation of ACOs changes the way organizations think about providing mental and physical health care to their population at risk. In this workshop, the authors hope to facilitate a comprehensive and multifaceted discussion of ACOs and their implications for mental health. We will begin by providing a background description of ACOs and how they fit into the broader landscape of alternate payment models. Next, we will present the results from a systematic review that aimed, in part, to describe the impact of ACOs on mental health care services. Focusing on the perspective of one large, urban academic health organization, we will then discuss how mental health care services have been planned and organized in the context of an upcoming ACO contract. This will include discussion of topics such as care integration and the design of health services for optimal value. Next, the authors will discuss the unique case of a direct ACO contract between an academic health care organization and a major corporation (without third-party payer involvement). This will allow us to discuss the intricacies of how mental health care may change in response to different types of ACO contracts. Finally, a psychiatrist will discuss their first-hand experience working in an organization transitioning to an ACO contract, highlighting how this impacted day-to-day clinical practice. Among other topics, this segment will include a discussion of lessons learned and strategies to navigate similar conditions at other institutions. We will end with questions and answers from the audience to the full speaker panel.

Addressing the Opioid Epidemic: A Public Health Approach

Chair: Georges C. Benjamin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the scope of the epidemic today; 2) Articulate three factors that were foundational as causes of the epidemic; 3) Describe

three things clinicians can do to address this from a clinical perspective; and 4) Identify two research and development needs

SUMMARY:

Opioids have become a significant public health problem that has been a major component of the reduction in life expectancy for the last three years. This is the first reduction in life expectancy since 1993 and is projected to grow in scope over the next several years. Multiple failures in the nation's disease, pharmaceutical surveillance systems, coupled with heavy marketing by pharma and over prescribing by clinicians contributed to this problem. Fixing it will not be easy and will require a multipronged approach across the entire spectrum of health to achieve success. Behavioral health specialists also play a role in addressing this problem.

Advocacy: A Hallmark of Psychiatrists Serving Minorities

Presenter: Esperanza Diaz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Name reasons to become an advocate; 2) Explain factors sustaining mental health services for minorities; 3) Identify the needs of Hispanic trainees; and 4) Name main learning objectives of an advocacy curriculum

SUMMARY:

The Hispanic population is the biggest minority in the United States (17.8%) and demographic trends suggest continued growth in the population. Psychiatrists must be aware of Hispanic patients' needs in order to provide mental health care that is culturally sensitive. Based on the knowledge that racial and ethnic minorities have less access to mental health services than Whites (Mental Health, Culture, Race, and Ethnicity Report, 2001), this session will provide compelling reasons for psychiatrists to become advocates. We will understand why advocacy is crucial. The presentation will review the social determinants of mental health with special emphasis on the Hispanic population, the history of advocacy and its relation to power. The development of sustained culturally

sensitive mental health services for monolingual Hispanics must be a priority and curriculum to address culture, social justice, structural factors, and advocacy will be used to exemplify the challenges and successes of achieving health equity. The learning needs of Hispanic trainees and the objectives of an advocacy curriculum will be addressed.

Antidepressant Use in United States Air Force Aviators and Special Forces

Chair: Kevin Floyd Heacock, M.D.

Presenters: Terry L. Correll, D.O., Ryan P. Peirson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the clinical experience and data gathering on aviators treated with antidepressants.; 2) Describe results obtained by studying aviators and special forces who have been treated with antidepressants.; 3) Understand how the USAF extensively evaluates and treats diagnoses treated with antidepressants in aviators and special forces.; 4) Examine the impact of allowing maintenance psychotropic antidepressants, psychotherapy, and performance of duty with psychiatric diagnoses.; and 5) Examine the use of antidepressant medication to reduce the aeromedical risk associated with psychiatric disorders.

SUMMARY:

This workshop will examine antidepressant use in United States Air Force (USAF) aviators and special forces. The USAF has long made various psychiatric disorders disqualifying for flight duties due to their potential adverse aeromedical impact on aviation safety and flying duties. Cognitive, emotional, and behavioral difficulties secondary to these disorders can lead to observable as well as subtle changes in functioning that negatively affect performance under physically and psychologically taxing conditions in aviation. Unidentified, untreated, or undertreated psychiatric conditions may have potentially disastrous consequences. To mitigate such outcomes, the FAA, Transport Canada, Australia, and the US Army have policies allowing selected aviators to fly while on certain antidepressants. The USAF has

followed suit over the last few years allowing select Flying Class personnel to be considered for waivers on the following monotherapies: 1. sertraline up to 200 mg/day 2. citalopram up to 40 mg/day 3. escitalopram up to 20 mg/day 4. bupropion SR or XL up to 450 mg/day While there are aeromedical concerns with the use of psychotropic medications for treatment as well, the USAF has had very positive outcomes to date.

APA Council on International Psychiatry the Global Challenge of Mental Disorders and Non-Communicable Diseases: The Role of Integrated Care

Chair: Paul Summergrad, M.D.

Presenter: Eliot Sorel, M.D.

Discussant: Gabriel Obukohwo Ivbijaro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Describe the increasing global burden of non-communicable diseases, including mental disorders; 2) 2. Explain the general concept of integrated care and broadly summarize at least three evidence-based models, including factors linked with successful implementation; and 3) 3. Using the collaborative care model of integrated care as an example, discuss how psychiatrists and professional organizations can work to decrease the mental health burden at home and abroad

SUMMARY:

Extensive data point to the growing burden of non-communicable diseases, including mental disorders, especially in low- and lower-middle-income countries. Mental disorders alone are responsible for nearly one in three years lived with disability globally, thereby placing extensive burdens on individuals, families, communities, and nations. When combined with the dearth of psychiatrists and other mental health providers in much of the world, the importance of developing new models to address mental health needs becomes more imperative. This session will review the genesis and support of integrated care, specifically the collaborative care model, within the American Psychiatric Association (APA); the development of similar perspectives and initiatives within

international psychiatric organizations such as the World Psychiatric Association (WPA) and the World Federation for Mental Health (WFMH); and other approaches that attempt to address the enormous needs for mental health care in low, middle and high-income countries. Evidence based models of integrated care will be presented including initiatives of the WPA, APA and WFMH . Perspectives from primary care will be incorporated, as will data on the growth of the mental health burden and evidence-based models of integrated and collaborative care that are attempting to reduce illness burden. Speakers include the current Secretary General of the WPA, a past president of the WFMH, the Chair of the Access to Care Committee of the APA Assembly and a past president of the APA. Time will be allotted for large group discussion, dialogue, and questions between presenters and participants.

Are We Zombies? Exploring the Modern Metaphor for Consumerism, Contagion, and Mindless Absorption in Electronic Media

Chair: Meera Menon, M.D.

Presenters: Nita V. Bhatt, M.D., M.P.H., Allison E. Cowan, M.D., Bethany Harper, M.D., Racheal Lee Johnson, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the history of the zombie metaphor in Western culture; 2) Illustrate via movie clips depictions of consumerism, contagion, and mindless absorption in electronic media.; 3) Explore the scientific literature behind media consumption and social media on mental health using small groups; and 4) Formulate strategies to guide treatment using the zombie metaphor into clinical practice in large group discussion

SUMMARY:

In the 1960s George Romero's Night of the Living Dead exploded into the cultural consciousness (Hardman and Steiner, 1968). The plight of a few survivors pitted against shuffling hoards of mindless monsters proved to be a powerful metaphor. Derived from the Haitian folklore of corpses reanimated by voodoo or witchcraft, zombies in current culture have expanded to stand in for consumerism, contagion, and the mindless

absorption in electronic devices and media. Romero's Dawn of the Dead (1978), set in a mall, is a critique of consumerism. Even Disney has weighed in on zombies with the recent release of Zombies (2018), which encourages tweens to be thoughtful about differences rather than just consuming the popular ideas about others. Contagion is another clear metaphor in zombie sources and, with the advent of so-called fast zombies, became even more terrifying. However, one of the more compelling recent metaphors is that of zombies caused by electronic media, phones, and devices. The movie Shaun of the Dead (2004) is more explicitly about going through life inattentively, absorbed not in the loved ones around oneself but in one's own solipsistic sphere. As American screen time and use of media increases, so do the concerns about mental health and mental illness (Nielsen, 2018; Weidman et al., 2012; Radesky, 2018). The literature on social media use is mixed with some reporting enhanced engagement with mental health treatment (Santesteban-Echarri et al., 2017). Other literature reflects that while depressed people can be comforted by social media, there is also a correlation between depression and use of social media (Pittman and Reich, 2016). Newer data indicates that the type of social media used is important in determining if it is helpful (Shensa et al., 2018). The presenters will host small groups to discuss types of media consumption and large groups to formulate specific strategies to better guide individualized treatment for the distraction that plagues society.

Better Care and Evidence-Based Treatment: An Introduction to the Clinical Support System for Serious Mental Illness

Chair: Tristan Gorrindo, M.D.

Presenters: Alexander S. Young, M.D., M.H.S., Amy N. Cohen, Ph.D., John Torous, M.D., Donna Rolin, Ph.D., A.P.R.N., Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the primary aims of the Clinical Support System for Serious Mental Illness initiative; 2) Articulate the education and practice needs of those engaged in the care of individuals with serious mental illness; 3) Identify what

resources are available on the SMI Answers website; and 4) Interact with the online SMI

SUMMARY:

The SAMHSA funded Clinical Support System for Serious Mental Illness (CSS-SMI) is an APA initiative that supports implementation of evidence-based, person-centered pharmacological and psychosocial interventions for individuals with SMI through the use of innovative technology and consultations to clinicians. Using an online website, SMIanswers.com, the project offers expert learning opportunities and consultation services support clinicians—including physicians, nurses, psychologists, recovery specialists, peer-to-peer specialists, and others—who provide evidence-based care for individuals with SMI. This session will familiarize attendees with SMI Answers and how it can help you provide better care for those with serious mental illness. During the session, the clinical expert team will provide an overview of the project, discuss available educational materials and the process for seeking a consultation, and provide an opportunity to interact with the website’s chat bot.

Black Minds Matter: The Impact of #BlackLivesMatter on Psychiatry

Chairs: Danielle Hairston, M.D., Ayana Jordan, M.D., Ph.D.
Presenters: Otis Anderson, M.D., Rachel Robitz, M.D., Sara Anne Baumann

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the history scientific racism and bias in American Medicine and Psychiatry; 2) Identify the impact of bias in psychiatric patient assessment and treatment; 3) Discuss the motivation for the creation of the Black Lives Matter Movement; 4) Discuss the value of resilience in the Black community; and 5) Identify methods for promoting mental health equity and empowering psychiatrists to provide culturally sensitive treatment to care for Black patients vulnerable to racial trauma

SUMMARY:

In 2013, in response to the acquittal of Trayvon Martin’s killer, Black organizers created a Black-

centered movement called #BlackLivesMatter. While this pivotal initiative had a major impact socially and politically, it additionally brought light to the experiences of Black patients in America. It both inspired new methods and reinforced previously established methods for assessing and treating Black people in America. It is important for us to be aware of the effect of racial trauma on the wellness of our patients. Discrimination-based traumatic stress can result in fear, anger, worthlessness, anxiety, depression, and humiliation. Literature has demonstrated the traumatic effects of Racism. Psychiatrists should recognize the impact of both historical and contemporary racism issues on their patients’ lives. Various factors contribute to the racial disparities in mental healthcare. This forum will help participants to understand the influence of social structures and biases on Black and other underrepresented minority patients. This session also aims to provide strategies for addressing racism and promoting mental health equity for our patients.

Building on the Strengths of Community: Addressing the Mental Health Needs of Korean Americans

Chairs: Stephanie Han, M.D., Eun Kyung Joanne Lee, M.D., M.S.
Presenter: Hyon Soo Lee
Discussant: Sheryl H. Kataoka, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review current mental health needs of the Korean American (KA) community, its care utilization patterns, and barriers to accessing resources/services.; 2) Understand the role of the Korean Christian church in potentially supporting mental health services for KA adults and children and the role of generation in seeking services.; and 3) Discuss intervention strategies to engage parents of children with mental health needs by partnering with KA community agencies.

SUMMARY:

According to the 2010 U.S. Census, Korean Americans (KAs) number approximately 1.7 million and are the fifth largest Asian American subgroup, yet they remain an underserved population with respect to mental health services, research, and

policy. This presentation will provide an overview of the intersection between KA immigration status, cultural and social factors, and mental health service utilization practices of KA children and adults. We will describe novel research aimed at improving access to care in KA communities through engagement of its community organizations. The first set of studies illustrates engagement of families through the Korean Christian church. Results of a survey of pastors serving KA communities explore the attitudes and beliefs of KA pastors and how they have responded to mental health concerns in their congregations. Key informant interviews conducted with pastors identify clergy's perceptions about their congregation's emotional and mental health needs and their experiences with addressing those needs and noted barriers to treatment. In addition to the church, KA community agencies can also play a key role in mental health service access, although few studies have been conducted that engage them in interventions for KA families. We will describe recent research documenting the needs of KA parents of children with Autism Spectrum Disorders (ASD) in seeking care, and how the data was then used to develop a novel intervention that involves a peer coaching model delivered by members of community-based agencies, that aims to help improve knowledge about ASD and improve parents' ability to access services for their children. We will conclude the session by highlighting the need for continued research and outreach efforts using key KA organizations, such as churches and community agencies, and discuss strategies to further engage not only the KA community and its leaders, but other immigrant communities as well.

Building Telepsychiatry and Technology Competencies Into Practice and Training

Chair: Robert Lee Caudill, M.D.

Presenters: Donald M. Hilty, M.D., Patrick T. O'Neill, M.D., Kishan Nallapula, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Participants will gain knowledge on how technology complements in-person care and is used to deliver psychiatric care.; 2) 2. Participants apply telepsychiatric practice standards and guidelines to clinical care and grasp

adjustments to clinical skills (i.e., competencies); and 3) 3. Participants learn how to integrate telepsychiatric and other technology competencies (e.g., mobile health, social media) into practice and training programs.

SUMMARY:

Telepsychiatry (TP) has quickly become a common and accepted model of psychiatric care delivery and current/future psychiatrists need to employ these and other technologies. Clinicians and residents-in-training need to acquire skills/competencies for TP, e-mail, text, mobile health and other technologies. Programs need seminars, rotations, supervisory and other training components to guide this work. Efforts are underway to document model programs and develop measurable competencies, which also requires faculty development, evaluation and change management provisions. Competencies may be organized as: 1) novice/advanced beginner, competent/proficient and expert/authority levels; 2) domains based on medical education and other frameworks; and 3) pedagogical methods to teach and evaluate skills. There is a large range in the implementation of telepsychiatry services within departments around the country and they are looking for guidance (e.g., modules; curricula); child and adolescent programs have perhaps more urgent challenges due innovation and complexity. The interprofessional literature (i.e., psychiatry/medicine, psychology, social work, counseling, marriage/family, psychiatric nursing, behavioral analysis) has excellent suggestions and workgroups are working with national organizations to develop consensus, certification and additional lifelong learning courses. These competencies, their implementation, and impact need more research and institutions need an integrated approach to social media/networking, telepsychiatric, and other technology developments for this new era of care.

Buprenorphine Update and Evolving Standards of Care

Chair: John A. Renner, M.D.

Presenters: Petros Levounis, M.D., Andrew John Saxon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain changing patterns of opioid use disorder; 2) Describe current efforts to expand medication treatment; 3) Explain changing models to expedite treatment admission; and 4) Describe evolving evidence-based standards of care for opioid use disorder

SUMMARY:

This session will describe recent changes in the epidemiology of opioid use disorder, including the current epidemic of fentanyl, carfentanil, and other fentanyl analogs. We will review: 1) Recent regulatory changes and their effect on clinical practice and collaborative care models 2) The results of research studies comparing buprenorphine and extended-release naltrexone 3) The impact of new medication formulations, including injectable buprenorphine 4) Evolving standards of care for medication-assisted treatment including models for the management of opioid over-dose and the efforts to reduce or eliminate barriers to admission to long-term medication treatment. 5) Plans to expand access to evidence-based treatment within the justice system.

Burnout and Depression: Different Challenges to Physician Health

Chairs: Laurel Mayer, M.D., Carol Ann Bernstein, M.D.

Presenters: Christina Maslach, Ph.D., Srijan Sen, M.D., Ph.D., Christine Moutier, M.D., Mickey Trockel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the key elements of burnout and depression.; 2) Appreciate the important commonalities between burnout and depression.; 3) Appreciate the significant differences between burnout and depression and the implications for treatment.; and 4) Be energized by the unique role psychiatrists can play in the development and implementation of a successful wellness program.

SUMMARY:

Recent years have witnessed an explosion of interest in the prevalence and consequences of burnout and

depression among physicians and front-line health care workers. Burnout is a work-related syndrome, commonly defined by emotional exhaustion, depersonalization and low perceived personal accomplishment. Depression is an illness, whose symptoms include depressed mood, anhedonia, changes in appetite or weight, and sleep, low energy, psychomotor agitation or retardation, guilt, difficulty concentrating and suicidal ideation. Data clearly demonstrate depression as a risk factor for suicide, but less is known about burnout as an independent contributor to suicide risk. There is significant symptom overlap between burnout and depression, yet the relationship between the two conditions remains unclear. This lack of clarity has important ramifications. There are known, evidence-based treatments for depression. There are fewer, if any, evidence-based treatments for burnout. The stigma related to burnout may be less than that related to having a mental illness, as burnout is a work-related syndrome and not a genetically-influenced DSM-V diagnosis. Relatedly, physicians may tend to accept that they have burnout, but not depression, unintentionally delaying access to effective treatment. Burnout interventions have usually focused on individual self-care strategies, but calls are being made to address work environment and organizational factors. This session will bring together experts in burnout, depression and suicide and will use case presentations to encourage an interactive dialogue with the audience about commonalities and differences between burnout and depression. The overall goal is to identify the critical targets for interventions and facilitate the development of successful wellness programs.

But I'm Not Racist: Racism, Implicit Bias, and the Practice of Psychiatry

Chairs: Lara J. Cox, M.D., Akeem N. Marsh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the concepts of systemic racism and implicit bias and describe real-world examples from medical and psychiatric history; 2) describe the detrimental impact of racism and implicit bias at multiple levels, from in-the-moment interactions of MD and patient to the ramifications for society as a whole; 3) discuss the

bias that is inherent in certain psychiatric terms and diagnoses, as well as consider biases in their application or use; 4) examine their own clinical thinking and practice and identify ways in which systemic racism and implicit bias may manifest themselves; and 5) improve skills for talking about issues of race, racism, and implicit bias with patients and colleagues

SUMMARY:

Implicit bias and systemic racism are hot topics when it comes to public discourse about issues like mass incarceration; in medicine, we talk about these concepts largely in terms of "social determinants of health," considering them in a relatively abstract manner and analyzing their impact at a public health level. Less commonly, we may discuss the role of racism in the experience of one specific patient. However, even during training, it is rare that we are asked to look within and examine the influence of racism and implicit bias on our own practice and decision-making. For most of us in medicine, reflecting on our own biases is extremely uncomfortable. We became physicians to help people, not hurt them. In our consciously articulated beliefs, we strive to be unbiased. We don't want to believe that we could hold racist ideas or act in ways that show prejudice. And because we hold fast to these ideals, when we hear stories about implicit bias or systemic racism in medicine, it is easy for us to dismiss them as tragic but unrelated to our own clinical practice. The problem is that implicit bias is not conscious. It is an automatic association between an attitude, idea, or stereotype and a group of people that is activated without intention or conscious control. It operates outside of our awareness. Put more simply, implicit bias is the tendency for stereotype-confirming thoughts to pass through our minds unnoticed, allowing them to affect our decisions and behavior. And implicit bias allows systemic racism to influence our thinking and our actions, even if on a conscious level we are strongly opposed to racist ideology. For example, many of us are familiar with the data on bias in antipsychotic prescriptions to youth in foster care, but we may not know that community mental health centers in minority areas prescribe fewer antidepressants than those in predominantly white neighborhoods. We may have learned in medical

school that rates of schizophrenia are higher in blacks than whites, but we were not taught about the influence of racial bias on the diagnosis' evolving criteria. We do not think about confirmation bias when we evaluate a black patient who seems mistrustful of the medical team, who accuses us of experimenting on him, and decide that he is guarded and paranoid - nor do we think about the history of racism in medicine, including the Tuskegee experiment, that may contribute to his fears. If he has been incarcerated, we may see "antisocial personality disorder" in his chart and become increasingly skeptical about his potential for change, without recognizing the contextual nature of that diagnosis or his history of trauma. As psychiatrists, it is essential for us to examine the influence of racism and implicit bias on our own practice in the service of justice, beneficence, and nonmaleficence. Furthermore, it is imperative for us to be able to discuss issues of racism and bias with our patients in a realistic, respectful way. We

CANCELED: Outcomes According to Delirium Motor Subtypes in Patients With Ischemic Stroke

Chair: Heewon Yang

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) the relationship between motor subtypes and demographic, general clinical characteristics of delirium in ischemic stroke patients; 2) the relationship between motor subtypes and stroke-specific clinical characteristics of delirium in ischemic stroke patients; and 3) the relationship between motor subtypes and outcomes of delirium in ischemic stroke patients

SUMMARY:

This session has been canceled.

Care for the High-Risk College Student: Three Innovative Programs for Crisis Intervention, Suicide Prevention, and Post-Hospitalization Care

Chair: Marcia R. Morris, M.D.

Presenters: Bryan J. McGreal, M.D., Melissa Gail Inga Eshelman, M.D., Nora Immordino Feldpausch, M.D.

Discussant: Haoyu Lee

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that mental health problems in the college population continue to rise in number and complexity, with an associated rise in self-destructive behaviors and psychiatric hospitalizations.; 2) Learn about innovative programs campuses have developed to provide care to high-risk college students including the Wellness Exchange, Intensive Outpatient Programs, and iTeam.; 3) Share with the audience programs that have worked at their university.; and 4) Choose one innovation they would implement in their practice to improve the care of the high-risk college student.

SUMMARY:

College mental health centers across the nation are experiencing increased severity and acuity in those students presenting for mental health concerns, including growing numbers of students admitted to psychiatric hospitals for suicidal thoughts and behaviors. Mental health concerns can provide a significant barrier to student success, contribute to decreased numbers of students able to successfully complete their degree, and provide a financial burden on both students and the university itself. As a result, many mental health providers serving college populations are working to develop innovative approaches to these serious mental health problems. Our session will review three unique programs developed for high-risk students that participants could incorporate into their own practices. The Wellness Exchange at New York University provides crisis intervention and assessment of high-risk students. It is a walk-in service staffed by crisis counselors, therapists, and psychiatrists 6 days per week with 24-hour phone coverage. High-risk students are reviewed weekly by their treatment teams. Hospitalized students are followed by staff to coordinate discharge planning and are seen the day following discharge. Evaluations assess whether the students are safe to return to classes with enhanced services or need a medical leave of absence. Completed suicides have been markedly reduced with this model. At the University of Texas at Austin, the Counseling and Mental Health Center (CMHC) collaborates with an off-campus community provider to operate an Intensive Outpatient Program (IOP) for the purpose of avoiding hospitalization or for students who are

discharged from the hospital. IOP provides students treatment that decreases suicide risk and improves mood and anxiety symptoms, which leads to improved academic functioning. IOP incorporates equity and inclusion for those students of low socioeconomic status who do not have health insurance or cannot afford to pay for services but would benefit from IOP treatment. A DBT informed post-hospitalization program called iTeam at Colorado State University provides students with recent mental health crises the support and skills they need to remain on campus and return to full academic functioning. We will review how iTeam was developed, current structure, challenges and successes as well as statistics regarding student participation numbers, CCAPS improvement, pre and post DERS scores, and percentage of students who are able to complete the academic semester. During our session, we will engage in a panel discussion about these programs. Participants will be asked to share their own successes and challenges in facing the increased rates of complex mental health problems on campus. Hearing about these programs will encourage others to look at ways they can improve their services for high-risk college students with the goal of promoting student wellness and academic success.

Caring for Veterans

Chairs: James K. Rustad, M.D., Douglas L. Noordsy, M.D.

Presenters: Samuel Isaac Kohrman, M.D., Ivan Chik, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand that combat veterans suffer a wide variety of war-related neuropsychiatric consequences (e.g., posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI)); 2) Define the Polytrauma Clinical Triad, Moral Injury, and Posttraumatic Growth; and 3) Identify that individuals with PTSD are at increased risk for medical conditions, particularly cardiovascular disease

SUMMARY:

Providing mental health care to veterans requires empathy and specialized knowledge. Our workshop

focuses on treatment issues facing clinicians working with veterans. Combat deployments affect the physical and mental health of veterans. Common mental health conditions encountered in veterans include PTSD, depression, suicide, substance abuse, traumatic brain injury, chronic musculoskeletal pain, medically unexplained symptoms (e.g., fatigue, somatic, and cognitive complaints such as memory, attention, and concentration difficulties), and sleep disturbances. Veterans are at higher risk of suicide than the general population. Individuals with PTSD have a higher risk of developing medical illnesses such as cardiovascular disease. The conceptual model of allostasis and allostatic load may serve as a mechanism through which stress, and more specifically PTSD, might precipitate medical illness. Allostasis is the adaptive process of maintaining homeostasis by expending and directing energy towards challenges, while allostatic load represents the cumulative cost to an organism of enduring repetitive cycles of adaptation. Our workshop will introduce screening tools important for the workup of veterans with mental health symptoms, including the PCL-5 PTSD screen, the Neurobehavioral Symptom Inventory, and the Columbia Suicide Severity Rating Scale. Participants will practice using these tools and will learn strategies to manage veterans with positive screens via interactive case examples. Our session will review evidence-based psychotherapeutic modalities and psychopharmacological treatments of PTSD. We will also discuss the use of physical exercise for managing allostatic load and brain recovery.

Catatonia in Susceptible Populations: Treatment and Management

Chair: Nery Diaz, D.O.

Presenters: Laura A. Clarke, M.D., Claire C.

Holderness, M.D., Abby L. Mulkeen, M.D.

Discussant: Andrew J. Francis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognizing catatonia in vulnerable populations; 2) ECT as effective treatment in catatonia, non responsive to lorazepam, chronic cases, and malignant catatonia; 3) Prevention of adverse sequelae in catatonia; 4)

Review use antipsychotics with catatonia in SMI; and 5) Maintenance treatment in catatonia

SUMMARY:

Catatonia syndromes have been described for centuries. Often missed and typically treatable, catatonia now has its own place in the DSM V. Catatonia can be seen across the life span and across different medical and psychiatric diagnoses. The aim of this presentation is to educate psychiatrists how to recognize symptoms of catatonia, how to promptly treat catatonia and how to avoid adverse outcomes in the treatment of catatonia. The presentation will include topics such as medical risk management, maintenance treatment, vulnerable populations, and ECT treatment. The topics of discussion will be delivered using didactic sessions followed by discussion.

Catching the Ticking Time Bomb: Novel Means of Assessing Imminent Suicide Risk

Chair: Lisa J. Cohen, Ph.D.

Presenters: Raffaella Calati, Ph.D., Karina Høyen,

Ph.D., M.Sc., Sarah Bloch-Elkouby, Ph.D., Thomas

Joiner

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the need to distinguish between chronic and acute suicide risk factors; 2) Identify both affective and cognitive markers of imminent suicide risk; 3) Understand the clinical utility of a suicide-specific diagnosis; and 4) List the criteria for the proposed DSM diagnosis of the Suicide Crisis Syndrome

SUMMARY:

Despite decades of research into suicide assessment and prevention, suicide remains a stubbornly persistent problem. In fact, over the past 30 years, there has been a remarkable 30% increase in the suicide rate across much of the United States. Moreover, many of these suicides occurred in people without a known mental condition. Further, although prediction of chronic risk, i.e., in months to years, is fairly well established, there has traditionally been less success in identifying predictors of imminent suicidal risk, i.e., in days to weeks. This is a critically important issue as studies

show that a very large fraction of suicide attempts are impulsive rather than planned. Hence it is imperative for clinicians to identify imminent risk in vulnerable patients and to do so for those without a diagnosed mental health condition and without relying on patients' report of suicidal ideation. Fortunately, there is now a growing body of literature on markers of imminent suicidal risk. In the present symposium, we bring together an international group of investigators to present cutting-edge research on the identification of acute risk factors for suicidal behavior. In the first presentation, we will present data on the Narrative-Crisis model of suicide. This model proposes that a stressful life event in patients with chronic vulnerabilities can trigger the Suicidal Narrative, a cognitive cascade leading impacted individuals to believe they are entirely worthless and alone. This in turn triggers the Suicide Crisis Syndrome, an acute negative affect state driven by a feeling of entrapment, finally resulting in suicidal behavior. We will next present data on the predictive validity of the Modular Assessment of Risk for Imminent Suicide (MARIS) with regard to suicidal thoughts. The MARIS is a novel, 4-part measure that combines assessment of the patient's Suicide Crisis Syndrome, the clinician's emotional response to the patient and standard suicidal risk factors. This instrument differs from standard assessments in that it incorporates the potent risk assessment capability of the clinician's own subjective intuition. We will then present data on the predictive validity of the MARIS with regard to suicide deaths in Trondheim, Norway. These data are unusual in that they assess suicide deaths rather than ideation or attempts. After this, we will present a network analysis of the proposed DSM criteria for the Suicide Crisis Syndrome, reconfigured as a suicide-specific diagnosis. Next, addressing the urgent problem of suicide risk in the military, we will present findings on re-experiencing and hyperarousal PTSD symptoms and imminent suicide risk in firefighters and active duty service members. Finally, the discussant will provide an overview of the presentations and will discuss their implications for suicide prevention and for future research.

Chronic Traumatic Encephalopathy: Challenges for Psychiatry

Chairs: Sivan Mauer, M.D., Nassir Ghaemi, M.D.

Presenters: Bennet Omalu, Amanda Woerman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To examine the origins and meaning of the concept of chronic traumatic encephalopathy (CTE); 2) To review recent studies on the psychopathology of CTE; and 3) To explore possible treatments for the psychiatric aspects of CTE, especially mood and suicidality

SUMMARY:

Chronic traumatic encephalopathy (CTE) has become an important new condition in neuropsychiatry. As a type of traumatic brain injury (TBI), CTE specifically occurs with repeated concussive or subconcussive impacts typically seen in high-impact sports or in modern warfare. It is seen now in athletes such as American football players, hockey players, and in boxers, as well as recent military veterans exposed to high-impact explosives, such as bombs. The symptoms of CTE include initial mood psychopathology, such as depression and manic impulsivity, with mild cognitive impairment that eventually worsens to full dementia. Suicidality also occurs and worsens, with notable cases of suicide. The scope of risk of CTE is unknown, such as whether it can be present after just a few years of high-impact athletic or military exposure, or requires a longer incubation. The frequency of CTE is debated, with post-mortem studies ranging from over 90% prevalence to lower rates. No defined diagnostic or treatment approaches to CTE have been developed, other than post-mortem brain autopsy, which shows severe tauopathy. Recent studies on diagnosis will be reviewed, as well as possible treatment approaches, including lithium as a potential agent for mood, suicidality, and dementia prevention. This symposium will include the discoverer of CTE, Dr. Bennet Omalu, and other psychiatrists and researchers who treat or study this devastating condition. Since CTE is new, it is important to bring it to the attention of clinicians, many of whom are exposed to high school, college, and later athletes who may be at risk.

Civil Commitment: Nadir to Zenith

Chair: Melissa K. Spanggaard, D.O.

Presenter: James Lyle Knoll, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the history of civil commitment; 2) Discuss variations in civil commitment laws; 3) Know the underlying case law which led to current commitment statutes; and 4) Know the underlying patient rights issues which led to current commitment statutes

SUMMARY:

Civil Commitment is the legal mechanism by which the government deprives persons of their liberty because of mental illness. The practice has an interesting and controversial history. The prevailing legal bases for civil commitment in the U.S. are *parens patriae* and police powers. This session will outline the history of civil commitment – stressing its evolution from an “in need of treatment” standard to a “dangerousness” standard. Special attention will be given to the so-called “criminalization” of civil commitment where the standard reached its zenith in the landmark case of *Lessard v. Schmidt* (1972), and the Court held that deprivations following civil commitment are “more serious than the deprivations which accompany a criminal conviction.” Speakers will review the progression of legal cases which have led to current standards. A video vignette and audience participation will be used to help participants become more effective at analyzing and opining on cases involving civil commitment. Areas of current misunderstanding regarding civil commitment will be discussed, including the “grave disability” standard and outpatient civil commitment.

Clinical and Neural Correlates of Autism Spectrum Disorder and Response to Glutamate Modulating Agent

Chair: Gagan Joshi, M.D.

Presenters: Joseph Biederman, M.D., Amy M. Yule, M.D., Sheeba Anteraper

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to grasp the morbidity and dysfunction and the stability and predictive utility of autistic traits (AT) in youth

with ADHD.; 2) The participant will be able to understand the risk for developing a substance use disorder (SUD) in individuals with autism spectrum disorder (ASD).; 3) The participant will be able to demonstrate a greater understanding of neurological biomarkers for ASD.; and 4) The participant will be able to appreciate the potential role of memantine hydrochloride for the treatment of social deficits in individuals with high-functioning ASD (HF-ASD).

SUMMARY:

Autism spectrum disorder (ASD) is a lifelong developmental disorder associated with high morbidity and disability (Kogan, 2009) that is estimated to affect up to 2% of youth in the general population (Blumberg, 2013). While there is increased recognition of ASD in intellectually capable populations (Baird, 2006), major gaps remain in our knowledge of the prevalence, morbidity, and dysfunction associated with the presence of autistic traits (ATs) that fail to meet diagnostic criteria for ASD. Furthermore, there remains a clinical need for understanding the risk and pattern of comorbid substance use disorder (SUD) in individuals with ASD. Gaining an up-to-date knowledge in these areas will encourage clinicians to recognize the presence of disabling ATs in their clinic populations and appreciate the risk of SUD in individuals with ASD. Additionally, there is emerging neuroimaging research focused on identifying neural biomarkers for ASD. Biomarkers can aid early diagnosis prior to the emergence of ASD features and/or guide therapeutic intervention and/or response. As such, clinicians will also benefit from the current state-of-the-art understanding of neural biomarkers in ASD. Lastly, there has been an effort to explore pharmacological options for the treatment of social deficits in ASD. Of particular interest are glutamate modulating agents, in particular memantine hydrochloride. It is therefore important to learn about the promising role of memantine for the management of core features of ASD. This session, intended for psychiatrists and other mental health professionals providing care for individuals with ASD, will address these topics in a panel presentation and discussion format. The first two presentations will discuss ASD and associated psychopathology. Investigating the stability and predictive utility of autistic traits in youth with ADHD, the first

presentation will report on the results of a 10-year longitudinal study of ATs in youth with ADHD. It will highlight the persistence of ATs in ADHD youth and their association with a higher level of dysfunction. The second presentation will discuss findings on the risk of developing a SUD in individuals with ASD. The subsequent presentations will address neurological biomarkers of ASD and the potential of memantine hydrochloride as treatment for ASD. The third presentation will report on a machine learning (ML) analysis of data from the Brain Genomics Superstruct Project. ML was used to identify regions of interest (ROIs) that are most predictive of a HF-ASD diagnosis based on resting state functional connectivity (RsFc) profiles in a given data set. The fourth and final presentation will address the role of glutamate modulators in the treatment of ASD and discuss the results of a recently-concluded controlled-trial evaluating the tolerability and efficacy of memantine hydrochloride for the treatment of social deficits in individuals with HF-ASD.

Community Activism Narratives in Organized Medicine: Homosexuality, Mental Health, Social Justice, and the American Psychiatric Association

Chair: Saul Levin, M.D., M.P.A.

Presenters: Patrick Sammon, Bennett Singer, Adrian Jacques H. Ambrose, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide culturally competent care for diverse populations; 2) Integrate knowledge of current psychiatry into discussions with patients; 3) Identify barriers to care, including health service delivery issues; and 4) Apply quality improvement strategies to improve clinical care

SUMMARY:

"Know from whence you came. If you know whence you came, there are absolutely no limitations to where you can go." James Baldwin's eloquence underscored the controversial history between organized medicine and the LGBTQ community: The pathologization of homosexuality in the Diagnostic and Statistical Manual of Mental Disorders. Guised under the justification of mental illness, blatant discrimination and stigmatization battered this

vulnerable sexual minority community. In 1973, the American Psychiatric Association (APA) unanimously voted to declassify homosexuality as a disorder; however, the stories and strategies of social activism surrounding this pivotal moment in the LGBTQ movement for equity were largely unknown. This session aims 1) to deconstruct and expound this painful thread of APA's involvement in the LGBTQ community, 2) examine key players in the pathologization of homosexuality, and 3) reexamine meaningful ways for medical organizations, such as the APA, to advocate for patients and vulnerable populations. Mr Sammon and Mr Singer will discuss the journey of investigating the narratives of the social activism within the LGBTQ community and the APA, culminating in the highly anticipated documentary entitled, "Cured." In addition, the award-winning filmmakers will discuss the process of creating an advocacy campaign ("Impact Campaign") that will focus on two key areas: 1) Educating healthcare providers, including medical students, residents, and fellows, and 2) Highlighting the effort to ban conversion therapy, which is a discredited practice to "convert" a person's sexual orientation. There are currently only 15 states and District of Columbia with specific statutes banning conversion therapy on the basis of sexual orientation and gender identity/expression.

Computer-Assisted Cognitive Behavior Therapy and Mobile Apps for Depression

Chairs: Jesse H. Wright, M.D., James H. Shore, M.D.

Presenters: Matt Mishkind, Ph.D., Steven Richard Chan, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify computer-assisted therapy methods for treatment of depression; 2) Identify mobile apps for treatment of depression; 3) Recognize methods for using computer-assisted CBT and mobile apps in clinical practice; and 4) Discuss advantages and limitations of computer-assisted therapy and mobile apps for depression

SUMMARY:

The development of computer-assisted cognitive-behavior therapy (CCBT) programs and mobile apps for depression has accelerated in recent years, and

clinicians now have an abundance of technological aides they can add to their therapeutic tool boxes. However, clinicians may not be fully aware of the potential of these technological aides for enhancing clinical practice. This workshop briefly reviews the evidence for effectiveness of CCBT and then illustrates CCBT programs, CBT mobile apps, and other apps that can be used in the treatment of depression. Participants will discuss advantages and limitations, clinical implementation, and future directions of CCBT and mobile apps.

Consultation, Critique, and Creation: Forensic Psychiatry's Historical Impact on the Entertainment Industry

Chair: Vasilis K. Pozios, M.D.

Presenters: Praveen R. Kambam, M.D., Jeff Trexler

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the components of Hollywood's Hays Production Code, developed in consultation with forensic psychiatrist Carleton Simon.; 2) Understand the principles underpinning forensic psychiatrist Fredric Wertham's theories on causes of juvenile delinquency in the 1950s.; 3) Appreciate the evolution of the modern media violence debate from its historical origins.; and 4) Appreciate the impact that forensic psychiatrists who have interfaced with entertainment media have made on popular culture.

SUMMARY:

The entertainment industry has made its mark on psychiatry. Fictional mental health depictions in classic films like *Psycho*, iconic novels including *One Flew Over the Cuckoo's Nest*, and controversial television series such as *13 Reasons Why* have – for better or for worse – shaped public perceptions of psychiatry. Less known is how forensic psychiatrists have left their own indelible mark on the entertainment industry. Through consultation, critique, and even creation, forensic psychiatrists have played prominent roles, both directly and indirectly, in irreversibly impacting the entertainment industry. Vasilis K. Pozios, M.D., and Praveen R. Kambam, M.D., of the entertainment consulting group Broadcast Thought share the little-known stories of psychiatrists Carleton Simon, M.D.,

and Fredric Wertham, M.D., prominent figures at the interface of forensic psychiatry and the entertainment industry in the early-to-mid 20th century. They will also discuss the contributions of renowned forensic psychiatrist Park Dietz, M.D., M.P.H., Ph.D., to Hollywood. As a consultant to Hollywood's infamous Hays Office, Dr. Simon played a pivotal role in the editing of films to meet state censorship board criteria. Not only did Dr. Simon shape the final versions of classic films such as *Scarface* (1932), he also participated in true-crime radio programs such as *Gangbusters* and even wrote fiction for pulp magazines. Dr. Wertham was critical of the role crime and horror comic books played in juvenile delinquency. Dr. Wertham's 1954 book, *Seduction of the Innocent*, and the subsequent anti-comics hysteria led to United States Senate subcommittee hearings. Ultimately, this resulted in the near-demise of the comic book publishing industry and the establishment of a self-censorship body, the Comics Code Authority. More well known are Dr. Dietz' contributions to Hollywood as a studio consultant, whose expertise proved invaluable to television series such as *Law & Order*, and films like *Primal Fear*. Attorney and comics historian Jeff Trexler contextualizes the historical significance of these psychiatrists' efforts and describes how their impacts are still felt in contemporary popular culture. Audience participation and polling relying on video clips and images will be used throughout the entire session.

Deportation and Detention: Addressing the Psychosocial Impact on Migrant Children and Families

Chair: Angela Devi Shrestha

Presenters: Schuyler Henderson, M.D., M.P.H., Luis Zayas, Ph.D., Sergio Aguilar-Gaxiola, M.D., Ph.D.

Discussant: Stevan Merrill Weine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate familiarity with the broader social and policy context of deportation and detention.; 2) Demonstrate understanding of the psychological consequences of deportation and detention on children, families, and communities.; and 3) Identify how psychiatrists, other mental health professionals, policymakers, advocates, and

academic researchers can work together to advocate for impacted children and families.

SUMMARY:

Though the White House's abominable "zero tolerance" policy of separating young children from their parents and placing them in inhumane conditions was discontinued, a reported nearly 2,500 children were forcibly separated from their parents and 500 remain apart. The chaotic environment of a detention facility is a dangerous place for children that further traumatizes them after their hazardous migrant journeys and the unimaginable pain of being torn from their parents. Adverse experiences during childhood, including disruptions of attachment relationships and other forms of child abuse, can cause a lifetime of mental and physical health consequences. Policies of forced deportation and detention have and continue to expose children, youth, families, and communities to adversity which has demonstrable psychosocial consequences. What lies ahead for these children and families? What can be done? How can psychiatrists and other practitioners, policymakers, advocates, and academic researchers work together to advocate for impacted children and families? This session aims to address these important questions and inspire a collaborative effort to take action in helping those who still live in daily fear. This session draws upon first person accounts, practitioner's reports, and research that documents the traumatic impacts of separation, deportation and detention upon migrant children, youth, families, and communities. It will bring together practitioners, advocates, and researchers to share knowledge and strategies on changing current deportation practices and ameliorating the impacts of these practices on youth and families.

Developing a Global Mental Health Program for Psychiatry Departments

Chair: Vivian Blotnick Pender, M.D.

Presenters: Myrna M. Weissman, Ph.D., James Lamont Griffith, M.D., Francine Cournos, M.D., Milton Leonard Wainberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe aspects of a global

mental health curriculum.; 2) List references that may be used to teach global mental health.; 3) Learn examples of global mental health projects.; 4) Improve cross-cultural competency.; and 5) Discuss research opportunities.

SUMMARY:

There has been a gap in the consistency of education, clinical training and research in the field of global mental health despite the World Health Organization report that mental illness constitutes a major cause of human dysfunction. The W.H.O. also anticipates that depression will be the number one cause of disability adjusted life years and years lived with disability by the year 2030. The limited numbers of educational courses that are being provided differ widely from one academic program to another. Although there is demonstrated interest in diversity among undergraduates, graduate students, medical students, and residents, most medical schools and academic institutions do not provide global mental health training. What training there is depends on available faculty with variable interests and experience. Some programs focus on social disparity and health inequity while others focus on human rights. What are needed are consistency and a mutually agreed definition of what constitutes the domain and training approaches of global mental health. An example global mental health program might aim to increase cross-cultural clinical competency and to build sustainable capacity in low-income communities. There is a need to standardize the content of global mental health education in the long-term view of establishment of fellowship training for psychiatry residents. This interactive meeting will solicit experiences from participants and audience members to propose a scope, definitions, a curriculum, references and examples of clinical and research projects.

Developing Psychiatric Drugs: Can We Do Better?

Chairs: Nassir Ghaemi, M.D., Wayne Drevets

Presenters: Peter Weiden, M.D., Amir H. Kalali, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To examine the history of drug development in psychiatry; 2) To understand the process of drug development in psychiatry; 3) To

critique weaknesses and limitations of current psychiatric drug development; 4) To propose new approaches for better psychiatric drug development; and 5) To review the limitations of currently available psychiatric drug treatments

SUMMARY:

The development of psychiatric drugs has been a source of both pride and contention. Many drugs are available, with the majority developed in the last 30 years, but there is discontent. Few breakthroughs have occurred in the past 20 years, with most new drugs being "me-too" copies of prior agents. The argument could be made that most drugs are symptomatic only in their effects, and do not impact underlying disease processes in any profound way. Therefore, given the many side effects and harms of current drugs, the efficacy obtained may not be a good tradeoff. Further, drug development generally happens in the setting of private enterprise, not academic medicine. Many concerns have been raised about the commitment and motivation of the pharmaceutical industry in the development of psychiatric drugs, which have been the source of major profits over the past decades. Now most major pharmaceutical companies have reduced or stopped psychiatric drug development. The impact of this retreat on current and future treatment of patients is a matter of concern. This symposium seeks to explore the above issues through the experience and views of prominent psychiatrists who are current or former academics as well as currently active in clinical drug development of major pharmaceutical companies. They provide viewpoints about how the current dead-end of psychiatric drug development might be broken, and new avenues to progress explored in relation to drug discovery and the processes/methodologies of research, unrelated to any specific disease or compound/drug.

Diagnostic Categories or Dimensions? How Studying the Neural and Genetic Bases of Dimensional Traits Can Help Us Find New Treatments

Chair: Maria Mercedes Perez-Rodriguez, M.D., Ph.D.

Presenters: David Goldman, Albert Russell Powers, M.D., Ph.D., Nikolaos Koutsouleris, Maria Mercedes Perez-Rodriguez, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the role of rare genetic variants in the discovery of new therapeutic targets for impulsive aggression; 2) Understand the advantages of dimensional approaches for identifying treatment targets; 3) Understand the neural and genetic overlap between schizotypy, schizotypal personality disorder and schizophrenia; 4) Describe the neural circuits and perceptual errors involved in auditory hallucinations across the psychosis spectrum, and their role in early diagnosis and individualized treatment approaches; and 5) Describe cognition and social cognition abnormalities across the schizophrenia spectrum, their neural circuit underpinnings, and emerging therapeutic interventions

SUMMARY:

The paradigm for elucidating the neurobiology of psychiatric disorders has shifted away from categorical diagnostic models and toward transdiagnostic dimensions of behavior. This dimensional model has been adopted by the National Institute of Mental Health (NIMH) as exemplified by the NIMH Research Domain Criteria (RDoC) initiative. This general session will introduce participants to the study of the neurobiology of dimensional, transdiagnostic traits, and how this approach can inform the discovery of new therapeutic targets and individualized treatments. This is particularly important for symptoms which are not adequately treated with currently available therapies (e.g., impulsive aggressive behaviors in Intermittent Explosive Disorder, Disruptive Behavior Disorders or Borderline Personality Disorder, and negative symptoms and treatment-refractory auditory hallucinations in schizophrenia). We will provide an introduction to transdiagnostic dimensional trait approaches including the NIMH RDoC initiative and the hybrid dimensional/categorical model of personality included in section 3 of the DSM 5. We will present several examples of studies examining the genetic and neural bases of the transdiagnostic dimensions of impulsive aggression and schizotypy. We will discuss how these studies can inform the discovery of new therapeutic targets and the development of new treatments. Speaker 1 will discuss efforts to

identify rare genetic variants associated with impulsive aggression, leading to the discovery of new therapeutic targets to treat aggression in psychiatric disorders. Speaker 2 will describe the neural and genetic overlap across the schizophrenia spectrum disorders and the advantages of studying non-psychotic schizophrenia spectrum disorders to identify new treatment targets for schizophrenia. Speaker 3 will discuss the neural circuits and perceptual errors involved in auditory hallucinations across the psychosis spectrum, and their role in early diagnosis and individualized treatment approaches. Speaker 4 will describe the cognitive and social cognitive impairment in schizophrenia spectrum disorders, the underlying genetic and neural circuit abnormalities, and testing of new therapeutic agents targeting negative symptoms and cognition. Participants will be engaged in the session using several strategies: 1) There will be live polling of attendees at the beginning and end of the session to compare their a priori knowledge of the learning objectives with enhanced knowledge after the session; 2) When appropriate, we will provide clinical cases and videos to illustrate relevant points of the discussion; 3) We will schedule time for expert panel discussion and Question and Answer interaction with attendees to encourage rich discussion.

Disparities in Mental Health Care Delivery to Immigrants: How Community Psychiatrists Can Close the Gap

Chair: Bernardo Ng, M.D.

Presenters: Angela Devi Shrestha, Jennifer Severe, M.D., Sasidhar Gunturu, M.D.

Discussant: Gabriel Obukohwo Ivbijaro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the disparities in mental health service use among immigrants.; 2) Describe the role of a community psychiatrist to address this disparity through problem recognition and treatment initiation.; 3) Identify ways to bring immigration-related issues into the psychiatric encounter.; and 4) Learn tools from a multisystem level to address disparities in mental health service use among immigrants.

SUMMARY:

Immigrants represent a substantial – and growing – percentage of the United States’ population. While concerted efforts in the field of psychiatry have helped improve healthcare utilization and access for several minority groups, the needs of immigrants remain under-addressed. Immigration to the United States is often driven by traumatic events or discrimination in their home countries. Moreover, the process of immigration itself can exacerbate or trigger psychological distress, and adjustment to a new culture presents significant internal conflict. Despite the increased need for mental health care among this population, immigrants have been found to consistently underutilize mental health services compared to non-immigrants. This disparity is compounded by the fact that many psychiatrists feel they are not adequately trained to address immigration-related issues in a clinical context. Community psychiatrists sit at a crucial junction for helping to bridge the gaps between immigrants and community services as they sit at the front line of patient care, as well as have a vantage point from a multisystem-level. This workshop aims to empower community psychiatrists to better address the disparities faced by immigrants in their communities. We will provide background education about the unique challenges of immigration and their effects on specific communities. Next, we will discuss data gathered from the 2018 American Psychiatric Association’s annual meeting, regarding individual psychiatrists’ level of comfort broaching the subject of immigration status during the psychiatric encounter. We will use case vignettes to illustrate ways in which psychiatrists can better assess and manage such issues within the context of a clinical encounter. Presenters will discuss their experiences with innovative programs to improve immigrants’ access to and utilization of mental health care and reduce stigma, including collaborative care models. The speakers will build on lessons learned from their national and international experiences in community psychiatry, systems of care and advocacy to provide the audience with practical tools to better assist the community they serve.

Disrupting the Status Quo: Harnessing Innovative Technology to Meet the Joint Commission Measurement-Based Care Mandate

Chair: Whitney E. Black, M.D.

Presenters: Corey Fagan, Ph.D., Sonia Thomas, M.D., Richard Leichtweis, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the rationale for measurement-based care (MBC); 2) Discuss revised TJC measurement-based care standard (CTS.03.01.09) and three elements of performance for accreditation; 3) Understand basic concepts of implementation science applicable to the implementation of measurement-based care via measurement feedback technology; and 4) Identify four provider level barriers to implementing measurement-based care and potential solutions

SUMMARY:

Measurement-based care (MBC), or the systematic use of patient-reported data to monitor treatment progress and inform care decisions, has consistently been shown to improve psychiatric treatment outcomes for adults and youths. Three decades of research has shown that MBC leads to greater symptom reduction and higher rates of remission compared to usual care. MBC has also been shown to shorten time to treatment response and remission, improving treatment efficiency. Given that MBC can enhance nearly any evidence-based intervention and the strong evidence for improving treatment outcomes, accrediting bodies, payers, and behavioral health professional organizations alike have pushed for the broad adoption of MBC. In 2015, the Centers for Medicare and Medicaid Services (CMS) and two commercial payers announced value-based payment programs that rewarded the implementation of MBC. In 2016, the American Psychiatric Association declared MBC to be an essential part of the Collaborative Care model. In 2017, CMS began levying reimbursement penalties for failing to track patient outcomes. Most recently, the Joint Commission (TJC), a healthcare accrediting body with ~21,000 healthcare organizations under its purview, issued a revised standard for measurement-based care in behavioral health settings. The revised MBC standard (CTS.03.01.09) mandates the routine use of standardized tools to monitor treatment progress and demonstrate outcomes. This likely constitutes a seismic shift in

operations for the majority of behavioral healthcare organizations in this country. Given the importance of accreditation, behavioral health providers will have to innovate and engage with how best to implement MBC and meet the TJC standard. During this session, we will review the revised TJC MBC standard and discuss how behavioral healthcare organizations can disrupt the status quo by implementing MBC to meet these standards using innovative technology. Strategies to address determinants of implementation on various levels (e.g., organizational, individual, process) will be presented. Finally, we will explore a case study of how a comprehensive community behavioral health clinic utilized these strategies to meet the TJC MBC standard using a commercially available measurement feedback software, and successfully navigated the TJC accreditation process for the first time since the new standard was adopted.

Disrupting the Status Quo: Addressing Racism in Medical Education and Residency Training

Chair: Constance E. Dunlap, M.D.

Presenters: John F. Chaves, M.D., Jessica Elizabeth Isom, M.D., M.P.H., Nhut Giuc Tran, M.D.

Discussant: Eindra Khin Khin

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the evolution and dynamics of race as a social construct and racism as a pervasive defense mechanism from a psychoanalytic perspective; 2) Identify the four domains of racism – individual, interpersonal, institutional, and internalized – and their impact on training and clinical treatment; 3) Understand how the biomedical framing of race contributes to physician bias and perpetuates health disparities; 4) Understand the differences between unconscious vs. conscious bias, Microaggressions, racial insensitivity, and racial discrimination; and 5) Identify alternative responses that validate, educate, and promote better treatment outcomes and more satisfying training experiences

SUMMARY:

Although most psychiatrists are unaware, medical students and residents are leading efforts to have courses on race and racism included in their

education and training. Recognizing a need to support these efforts, in May 2018, the APA Assembly approved a position statement and an action paper affirming its commitment to provide education about racism and racial discrimination in medical education, residency training, and continuing education programs. While most psychiatrists agree that racialization can lead to physician bias and health disparities, many are unaware of the effect that their own unacknowledged biases can have on therapeutic and supervisory relationships. Using a panel of speakers, we provide a psychoanalytic understanding of the evolution of race and racism in America. We review the four domains of racism – individual, interpersonal, institutional, and internalized. We explore how the biomedical framing of race reinforces physician bias and leads to poor outcomes. We review relevant key concepts such as projective identification, bias, microaggressions, racism, intersectionality, and health disparities. We provide clinical vignettes to prompt discussion. Ultimately, we conclude by identifying recommended changes to the medical education and residency training curricula that would eliminate knowledge deficits among medical students, resident fellow members, and their instructors and supervisors and, ultimately, enhance clinical treatment and reduce disparities.

Drawing on Your Resilience to Prevent Burnout and Remain Engaged

Chair: Joseph C. Napoli, M.D.

Presenter: Rashi Aggarwal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this workshop, the participant should be able to: 1. appreciate how burnout and compassion fatigue can inflict physicians; 2) 2. enumerate 12 characteristics of individual resilience; 3) 3. self-assess their resilience; and 4) 4. draw on aspects of resiliency that were internalized via Active Collaborative Experiential Learning.

SUMMARY:

What is the risk to physicians by their being faced with ever increasing and burdensome demands and

requirements? What is the risk to physicians by their being empathic and giving clinical care? 42% of physicians surveyed report being burned out. Burnout negatively impacts patient care, working with colleagues and staff, and personal life. American Psychiatric Association President Dr Altha Stewart's theme for this Annual Meeting – Revitalize Psychiatry: Disrupt, Include, Engage and Innovate – focuses on the big picture. To revitalize psychiatry, individual psychiatrists need to revitalize. What do you need to include in your personal armamentarium to disrupt the development of burnout? How do you build wellbeing and prevent burnout in order to remain engaged? What innovative actions can you take? This workshop will provide answers via interactive presentations and Active Collaborative Experiential Learning (ACEL). Although experiential learning is a tried and true method with a long history, it is being applied innovatively to building resilience. People know burnout when they experience it but what is resiliency or resilience? A definition will be given and 12 characteristics of individual resilience will be described. Next, aspects of resilience will be highlighted in order to explain various resiliency exercises in which the participants will engage. Then the participants will form into groups and carry out another exercise to enhance their resilience. The participants will regroup to discuss their experiences in doing the learning exercises. Finally, the participants will perform an exercise that accentuates the positive and illustrates five themes of building resilience.

Ecological Grief, Eco-Anxiety, and Transformational Resilience: A Public Health Perspective on Addressing Mental Health Impacts of Climate Change

Chair: David Alan Pollack, M.D.

Presenters: Ashlee Cunsolo, Marshall Burke, Elaine Miller-Karas

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The learner will gain a clear understanding of the imminent and critical risks to general, mental, and public health posed by climate change.; 2) The learner will recognize the reality of ecological grief and ecoanxiety as relevant mental

health factors affecting a significant portion of the global population.; 3) The learner will understand the direct impact that environmental factors, such as increased global temperatures, have in relation to increased suicide rates.; and 4) The learner will become familiar with the concept of Transformational Resilience as a valid public health intervention to assist communities to prepare for CC and to remain healthy.

SUMMARY:

There is abundant evidence that climate change (CC) is the greatest public health threat for populations throughout the world, now and into the future. In this session, we will provide data from recent studies and discussion that underscore the significant and disruptive mental health impact of CC, including increased suicide rates and increased rates of anxiety and grief about the environment, e.g., higher temperatures, rising sea levels, extreme weather events, wildfires, etc. We will then present the concept of transformational resilience as a community-based intervention to assist communities to become better prepared to mitigate, reverse, and prevent the impacts of CC while maintaining community health and cohesion.

Electronic Health Record Adoption in Psychiatric Settings: Lessons From the Field

Chair: Alisa B. Busch, M.D.

Presenters: John Luo, M.D., Todd E. Peters, M.D., Alisa B. Busch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Understand the complexities of federal and state privacy policies and the challenges they pose for implementing EHRs in psychiatric care.; 2) 2. Understand the role that the federal Meaningful Use program had on spurring adoption in non-psychiatric settings.; 3) 3.

Recognize the challenges of implementing EHRs in integrated care settings.; 4) 4. Identify at least two areas of psychiatric care or workflows that are unique to psychiatry and are challenging to implement in electronic health records.; and 5) 5. Identify at least two solutions that have been implemented in some organizations to address the challenges of EHR adoption in psychiatric settings.

SUMMARY:

New forms of health care redesign and payment reform, such as accountable care models, offer opportunities to better serve individuals with psychiatric illness and aim to improve mental and physical health care quality and outcomes. These models require robust information sharing between psychiatric providers, and across medical and psychiatric providers. Electronic health records (EHRs) will play a large role in health care redesign efforts. However, EHR adoption in psychiatric settings lags considerably behind adoption in other medical settings. Creating a well-coordinated, high quality, and safer health care system will require more robust adoption of EHRs among providers of psychiatric care. While there are several reasons for limited EHR adoption in psychiatric settings, there are two prominent challenges: 1) the unique workflows and provider roles in psychiatric care; and, 2) the complex and varied federal and state privacy laws that dictate which and how psychiatric health information is shared. Our session will introduce participants to a more comprehensive understanding of the complexity of federal and state privacy laws and their implications for EHRs in psychiatric care. This panel will provide a unique opportunity for participants to learn about the challenges, and solutions, being employed in hospital-based settings for psychiatric care, through the lens of psychiatrists who are in informatics leadership positions in their health systems.

Empowering Providers to Successfully Treat Patients Without Homes

Chair: Ana T. Turner, M.D.

Presenter: Colleen E. Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Establish skills that will help providers engage patients who are experiencing homelessness in meaningful treatment relationships; 2) Identify which basic needs should be included in initial assessments and essentials of inpatient discharge planning for those living on the streets; 3) Identify ways to set practical limits and to keep patients engaged in treatment, especially related to the “tri-morbidity” of mental illness, addictions, and

life-threatening medical disorders; and 4) Highlight specific innovative programs we have found effective in serving those with mental illness experiencing homelessness

SUMMARY:

Substance, physical and mental health issues among those who are homeless is often limited to crisis response and emergency services. Ultimately, people who are uninsured and experiencing homelessness cycle in and out of crisis and health systems, resulting in high community costs but limited improvements in health. For providers treating such patients, a sense of hopelessness can arise, feeling unequipped to deal with the various needs of such “frequent fliers.” We propose a 90minute workshop aimed at empowering both inpatient and outpatient providers to feel equipped to deal with the various needs of those who might be more adequately dubbed “familiar faces.” We will begin the workshop by establishing skills needed to take the first step of fostering care of those with mental illness that are experiencing homelessness. Those with mental illness rightfully view the mental health care system with apprehension, and for this reason it is important to engage them patiently to cultivate a relationship that acknowledges the worth and dignity of the patient. The initial assessment of such patients must include assessing access to shelter, food, clothing and safety, certainly analogous to Maslow’s Hierarchy of Needs, but often taken for granted in most practice of medicine. We will also help providers recognize essentials of inpatient discharge planning for those living on the streets including pragmatic interventions for obtaining and safely storing prescription medications, personal identification, transportation, and creating actionable strategies to obtain emergency, transitional, or permanent housing. We will then discuss macro-level changes that can be made within communities to target homelessness. We will highlight how Sulzbacher, Northeast Florida’s largest provider of comprehensive services for homeless men, women and children, has specific programs aimed to treat the “tri-morbidity” of mental illness, addictions, and life-threatening medical disorders in those experiencing homelessness. Among these services is the city-funded mobile outreach initiative, the HOPE team, a

multidisciplinary assertive outreach program that seeks to engage homeless persons in treatment and case management. We will discuss the success of partnering with the University of Florida to educate the next generation of doctors in the outreach model with both medical students and psychiatric resident rotations. We will also discuss our partnership with community agencies to establish the Chronically Homeless Offender Program, identifying chronically homeless repeat misdemeanor offenders and helping these individuals get off the streets and reduce incarceration costs for the Sheriff’s office and Duval County Jail. Other unique services we will highlight include Florida’s first Trauma-informed day care, and our Medical respite program, a short-term transitional unit that stabilizes a homeless patient’s medical conditions so that they can transition safely to self-care.

Empowering Trainees to Engage in Scholarly Work and Leadership Role

Chair: Donna Marie Sudak, M.D.

Presenters: Muhammad Zeshan, M.D., Cathryn A. Galanter, M.D., Jose P. Vito, M.D., Sadiq Naveed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Enable programs, especially with limited funding and resources, to incorporate novel strategies to improve interests of residents in scholarly work, and facilitate development of academic clinicians.; 2) Provide list of resources to help medical students and residents in writing/publishing posters, abstracts, case reports, and articles.; and 3) Addressing apprehensive belief around meticulousness of research work, especially among residents with limited research experience.

SUMMARY:

Residency-based exposure to research will help trainees to assimilate emerging theoretical knowledge about biology, neurotransmitters, genetics, epigenetics, impact of trauma and other psychosocial stressors on patient’s current presentation, and strengthen the evolution of best psychiatry practices on routinely basis. Although, the Accreditation Council for Graduate Medical

Education (ACGME) requires that programs provide list of residents' annual scholarly activities, but there is scarcity of specific recommendations on how to achieve this professional milestone, especially for programs who have limited funding and resources. As a result, different programs have designed various strategies to meet the mandatory ACGME requirement, resulting in inconsistencies in satisfaction among residents across the US (1). Studies have repeatedly demonstrated that engaging in scholarly projects during training helps residents to interpret the literature, apply evidence to patient care, demonstrate competency in research methods, pursue a career in academic medicine, and ultimately achieve higher academic ranks. It also adds to the program's ranking and enhances its profile by increasing the departmental publications, poster and oral presentation at conferences, and nomination of their residents for regional and national awards (2). Despite the overarching benefits, residents find it challenging to pursue scholarly work due to limited number of formal research training opportunities, increasing pressure on mentors to maintain revenue based clinical activities, lack of clarity and consistency among programs about setting scholarly goals and providing protected scholarly/research time. A trainee's lack of enthusiasm, possibly due to apprehensive beliefs around the meticulousness of research work, and prospects regarding utility of research in their clinical practice may also serve as impediments. The National Institute of Mental Health has also noted a decline in the number of psychiatrist-researchers as compared to other medical specialties (3), (4) (5). The aim of our workshop is to enable programs, with limited funding and resources, to overcome some of the aforementioned challenges by providing lists of short courses on putting together research proposals, abstracts, as well as designing a poster. We will also share names of resident friendly journals and conferences along with useful strategies to start with reachable / sustainable goals like case reports and literature reviews. Moreover, we will discuss how to find a topic, approach a mentor, and create a research friendly environment during training. We will also furnish some tips to assist program directors to write letters supporting their residents, often necessary to obtain research grants

and applications for prestigious leadership awards and honorary fellowships.

Enhancing Clinical Skills in the Assessment and Management of Patients Suffering From Conversion Disorder

Chair: Andrew K. Howard, M.D.

Presenter: Anton Scamvougeras

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an understanding of the current evidence of the pathophysiology and management of conversion disorders; 2) Demonstrate skills in establishing rapport, history-taking, and the cognitive and physical examination, to definitively identify the presence and cause of the condition; 3) Utilize a pragmatic model to customize an approach to addressing and resolving psychiatric and psychological antecedents to the condition; 4) Identify elements of the understanding, assessment, formulation, and management of their own patients with conversion disorder to determine challenges and obstacles in their care; and 5) Understand the common pitfalls and limitations of assessment and management of patients with conversion disorder and how these are typically identified, addressed, and resolved

SUMMARY:

Conversion disorder occurs when an individual expresses emotional distress indirectly as neurological symptoms when no physical pathology in fact exists. It is the 'elephant in the room' for modern medicine. We know it is there, yet we seem to pretend it is not. Despite a remarkably high prevalence of this condition in neurology clinics and in general practice (with presentations as varied as non-epileptic seizures, functional movement disorders, cogniform disorders, persistent post-concussion symptoms, complex regional pain syndrome, and incongruous sensorimotor disturbances) it is strikingly under-identified and, more often than not, ignored. An unfortunate collusion keeps this condition hidden. The process whereby physical symptoms are generated by emotional distress is unconscious. The patient believes a physical illness is causing the problem, has little or no insight into the nature of the disorder,

and therefore understandably seeks, and even insists upon, help for what is perceived to be a physical rather than psychiatric condition. The persistent and common stigma against those presenting with overt manifestations of emotional or psychological distress compounds the difficulty in consciously identifying physical problems as psychiatric in origin. At the same time, clinicians largely find conversion disorder difficult to understand, and even more difficult to manage. Many physicians, even those specialized in psychiatry, will complete their training with the strong impression that sufferers are a very challenging population to treat, especially those with neurological disease comorbidity. Despite these challenges, conversion disorder is common and important. By virtue of the very significant burden of suffering borne by patients, and the consequences for their families, and the relative impact on communities in comparison to many other important diseases, one can easily make an argument for the need for specialized multidisciplinary clinics to assist individuals with conversion disorder. Even in the absence of specialized clinics, conversion disorder is treatable. We aim, in the session, with the benefit of evidence-based knowledge and the input of our group of treating clinicians with more than 120 years of collective experience assessing and treating inpatients and outpatients with conversion disorder, to lay out for clinicians a straightforward approach to understanding, assessing, and managing conversion disorder, akin to a rotation working with specialists focused on this patient population. We hope to show that they are, indeed, 'approachable' using this framework, that the work is gratifying and patients can be motivated and appreciative and benefit from the model, and that straightforward management built on the understanding we can give them can more often than not assist those suffering from conversion disorder.

Facing the Challenges of Misuse and Abuse of Stimulant Medications for ADHD: From Neurobiology to Clinical Care

Chairs: Jeffrey H. Newcorn, M.D., Anthony Leon Rostain, M.D.

Presenters: Iliyan S. Ivanov, M.D., Lenard A. Adler, M.D., Jeffrey H. Newcorn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • Appreciate the extent to which stimulant medications used to treat ADHD are misused and abused, and understand the different ways in which this occurs; 2) • Learn about the neurobiological pathways that underlie risk for substance abuse, and how these differ in youths with ADHD at relatively low vs. high risk for substance abuse.; 3) • Learn about the importance of utilizing quality measures to assess ADHD in adults, and about an important ongoing project to develop quality measures in this population.; and 4) • • Understand that using non-stimulant medications when indicated, and prioritizing the use of long-acting stimulants with lower abuse potential, can help to decrease medication misuse and abuse

SUMMARY:

Methylphenidate (MPH) and amphetamine stimulant formulations are the main medication treatments for attention deficit/hyperactivity disorder (ADHD). Because stimulants can produce euphoria when used in high doses orally or via alternative routes of administration, they have potential for abuse and misuse, and are classified as Schedule II controlled substances. Use of stimulants for ADHD in the US increased by 35.5% from 2008 to 2012. A recent study in the American Journal of Psychiatry using NSDUH survey data from 2015 and 2016 found approximately 30% of adults prescribed stimulant medications misused them, and 2.5% of them had substance use disorders (Compton, 2018). Identifying patients at risk for nonmedical use (NMU) of stimulants is an important goal for healthcare providers, and efforts to decrease NMU have been recommended by many leading professional organizations. This symposium will present information regarding NMU of stimulants, based on recent systematic reviews of evidence. We consider epidemiology, risk factors, and outcomes of stimulant NMU, and we summarize approaches for identifying and reducing the risk of NMU. In addition, we consider the mechanisms through which stimulant medications might potentially contribute to the development of substance abuse via their impact on reward mechanisms in high risk

individuals who have been shown to have altered reward sensitivity (Ivanov et al., 2012). Next, we present ongoing work on the development of quality measures for the assessment and treatment of ADHD in adults. This effort is being conducted by the American Professional Society for ADHD and Related Disorders (APSARD), with input from the APA Committee on Quality and Performance Measurement (CQPM). The identification and promotion of quality measures for adult ADHD is an important development, because there are no current U.S. professional standards for ADHD diagnosis and treatment in adults, yet over 8 million U.S. adults suffer from this condition. Finally, we present not yet published information on comparative effectiveness of stimulant (MPH) and non-stimulant (atomoxetine (ATX)) treatment in youth with ADHD based on data from a large, two-site, randomized crossover study - including key information about patient satisfaction and the impact of different treatment sequences (i.e., which medication is given first) on outcome. We note that in this and other studies (Newcorn et al., 2008), using a non-stimulant first improves the likelihood that this medication will be effective and positively received, and does not bias against stimulant efficacy in case of suboptimal response. A variety of other research highlights the importance of using long-acting stimulants and formulations that are not easily injected or inhaled as important methods for decreasing stimulant abuse. All of these methods will be discussed.

From Preconception to Parenthood: Ethical Considerations in the Psychiatrically Ill Pregnant Woman

Chair: Melissa Wagner-Schuman

Presenters: Angela Devi Shrestha, Brandi Jackson, M.D., Alexia Copenhaver, M.D.

Discussant: Nada Logan Stotland, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To provide an overview of the intersection of perinatal mental health and obstetrical and gynecologic care; 2) Identify and discuss the sequential barriers that arise during the course of pregnancy for women with mental illness due to the necessity for interprofessional care and

collaboration; 3) Discuss ethical challenges that women and their providers face in regards to decisions related to termination, consent, decision-making capacity, parenting and guardianship; and 4) Discuss strategies to address ethical barriers and outline guidelines for the stages of pregnancy and challenges faced

SUMMARY:

Patients, psychiatrists and obstetricians are frequently called upon to make concrete decisions about treatment, delivery, and postpartum care in the setting of serious mental illness. This daunting task is often fraught with ethical questions that practitioners may struggle to reconcile, or worse, fail to consider. Furthermore, mental illness can render patients incapable, to varying degrees, of participating in decisions regarding their care. At the University of Illinois, we have a comprehensive women's mental health program that spans both inpatient and outpatient. This allows us to provide specialized treatment of women from conception to delivery including those who require acute inpatient care. Given this unique population in an ever-evolving setting we have developed a collaborative environment to help address the obstacles faced by women with SMI and their providers throughout the pregnancy life-cycle. Experts will present real-life cases illustrating the unique dilemmas that arise in this population with the goal of helping mental health professionals recognize, analyze and manage these dilemmas. The cases discussed will highlight challenges faced throughout pregnancy - from conception to the postnatal period. Specifically we will discuss challenges faced when counseling the woman with SMI about reproductive health, including pregnancy termination, to offer a collaborative approach that includes obstetrics, gynecology, family planning, mental health professionals and the patient. We will provide examples that clarify best practices and evidence-based pharmacologic management of pregnant women with SMI throughout all three trimesters. In addition, we will discuss cases involving the assessment of capacity and its relation to procedural consent, including cesarean section. Finally we will discuss considerations regarding care of the newborn to connect issues that concern social work, foster care, and inevitably the legal system, as these

may present unexpected challenges to the health care team. This session will serve to provide a framework on which to build greater comfort in treating this vulnerable population. Armed with the knowledge gained from this session, mental health professionals will be inspired to foster thoughtful interactions among interprofessional teams and be better equipped to advocate for and optimize the care of the pregnant and mentally ill patient.

Global Psychiatric Education for Different Stakeholders

Chair: Roger Man Kin Ng, M.D.

Presenters: Afzal Javed, M.D., Donna Marie Sudak, M.D., Han-Ting Wei, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate that psychiatric training is needed for many stakeholders in community mental health care; 2) Appreciate that novel strategies and approaches in education can be utilized to engage different stakeholders; and 3) Appreciate that there are multiple challenges and pitfalls in psychiatric education for different stakeholders

SUMMARY:

This is an overview of psychiatric education for different stakeholders. Dr Afzal Javed will speak about WPA's action plan on teaching and training initiatives, followed by Dr Donna Sudak on how to make residents experts in psychiatry. Dr Roger MK Ng will share WPA-WONCA survey of WPA members on the types and appropriateness of having primary mental health competencies for family doctors. Lastly, Dr David Wei talks about his mental health educational initiatives for health workers of patients with HIV and substance abuse.

Good Psychiatric Management of Borderline Personality Disorder: Practical Applications

Chair: Lois W. Choi-Kain, M.D.

Presenters: Daniel Price, M.D., Richard G. Hersh, M.D., Benjamin H. McCommon, M.D.

Discussant: John Gunder Gunderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Outline the core components (i.e., formulation, strategies, tasks, and principles) of Good Psychiatric Management (GPM) for borderline personality disorder (BPD); 2) Elucidate its application in a number of common clinical such as inpatient hospital, outpatient clinics, and college mental health services; 3) Describe its application to other personality disorders; and 4) Outline how supervisors of trainees can utilize GPM as a basic approach to clinical management of BPD

SUMMARY:

This course will provide a preview practical applications of Good Psychiatric Management (GPM) for borderline personality disorder (BPD), an evidence based generalist treatment approach to this prevalent, challenging, and complex diagnosis which we know has a good prognosis and response to tailored therapeutic interventions. GPM contrasts most manualized treatments for BPD, which emphasize lengthy complex psychotherapies aimed at bringing about deep psychological changes. Such therapies are for specialists. There is strong reason to believe that with shorter-term, less demanding interventions, the majority of patients with BPD can and will get better, as well, or nearly as well as those who receive their care by specialists. Longitudinal studies of the past 20 years convincingly show that most borderline patients go on to remission or even to recovery in the absence of intensive specialized evidence-based treatments. Here, we are directing attention to the majority of patients who are not seeking such psychotherapies and to the majority of clinicians who are neither primarily psychotherapists nor BPD specialists. This course addresses to health professionals who simply want to take better care of the patients with BPD who come under their care with the goal is to help them move on with their lives. In this course, we will teach participants to use GPM in inpatient psychiatric hospital admissions, general outpatient adult psychiatric clinics, and college mental health settings. We will additionally discuss applications of the GPM framework to other personality disorders, such as narcissistic personality disorder (NPD), as well as in psychotherapy supervision for psychiatric residents. We will utilize clinical vignettes to illustrate these approaches, and

end with a moderated discussion of pragmatic concerns and practical strategies.

Hierarchical Taxonomy of Psychopathology (HiTOP): A New Approach to Diagnosis for Clinicians

Chair: Andrew E. Skodol, M.D.

Presenters: Robert F. Krueger, Ph.D., Camilo J. Ruggero, Ph.D., Roman Kotov, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the principles underlying empirical approaches to classifying psychopathology, and the role of the HiTOP consortium in pursuing these principles.; 2) Recognize how HiTOP constructs fit within the context of a routine clinical diagnostic interview.; 3) Understand how an evidence-based model of diagnosis can improve psychotherapy research and practice.; and 4) Understand the principles of a HiTOP approach to patient evaluation for case conceptualization and treatment planning in outpatient settings.

SUMMARY:

The Hierarchical Taxonomy of Psychopathology (HiTOP) is a quantitative, empirically-derived classification of psychopathology aimed at addressing many of the limitations of standard categorical classifications such as the DSMs. A reliable, valid, and clinically useful classification system for mental illness is necessary to facilitate communication among providers and with patients, to orient and guide treatment planning, and to provide information about the natural course of illness against which to measure treatment's effectiveness. The grouping of signs, symptoms, and personality traits into coherent dimensional components in HiTOP is based on statistical analysis; these, more narrow groupings are in turn combined into progressively broader dimensions of psychopathology reflecting commonly encountered syndromes, subfactors (for co-occurring syndromes), and spectra (for co-occurring subfactors). Assessment with HiTOP is highly flexible, and results can be represented by constructs at any level of the hierarchy based on available time, information, clinical resources, and patient needs. In this general session, presenters involved in the development of

the DSM-5 or HiTOP (or both) classification systems will introduce the audience to the basics of empirical approaches to classifying psychopathology, as represented by HiTOP, and suggest how clinicians might find HiTOP more useful than traditional classifications in their practices. How HiTOP constructs fit within the context of a routine clinical psychiatric diagnostic interview will be illustrated, and a case will be presented for a discussion of HiTOP diagnosis with the audience. The clinical utility of an evidence-based model of diagnosis will be illustrated in relationship to psychotherapy practice and research. Principles for implementing HiTOP into a general mental health outpatient clinic will be presented, including overall logistics, sample measures for the evaluation of HiTOP constructs, approaches to multidimensional case formulation and their relevance for treatment planning, and necessary clinician training. Principles of case formulation and treatment planning will also be illustrated with case examples for audience discussion. This session employs a combination of didactic presentation (roughly 2/3 of the allotted time) to inform audience participants of basic principles of HiTOP classification and audience participation (roughly 1/3 of the time) by means of case discussions and opportunities for Q&A with the presenters.

High-Functioning Professionals With Neurocognitive Disorders: Fitness for Duty and Ethics Considerations

Chair: William Connor Darby, M.D.

Presenters: Robert Weinstock, M.D., Ryan Darby, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the clinical symptoms of differing neurocognitive disorders and how they are diagnosed; 2) Describe the role and limitations of neuroimaging and biomarkers in predicting the progression of symptoms in neurocognitive disorders; 3) Describe the possible role for neuroimaging in fitness for duty evaluations; 4) Describe the competing ethics considerations to weigh and balance when performing a fitness for duty evaluation on a high-functioning professional who has mild cognitive impairment symptoms; and

5) Explain how dialectical principlism can be implemented to resolve ethics dilemmas in the field of psychiatry

SUMMARY:

Neurocognitive disorders are characterized by a progressive deterioration in cognition and behavior with impaired functioning in daily life. Misfolded proteins are the underlying pathology, but clinical symptoms of cognitive impairment and behavioral abnormalities do not correlate precisely with the actual pathology. All dementias affect decision-making, and impaired decision-making can be the basis for persons being found legally to no longer be fit for duty in their respective professions. Determinations for fitness for duty for persons with neurocognitive disorders are predominantly based on cognitive assessments that include neurocognitive battery tests. New neuroimaging techniques and biomarkers of neurocognitive disorders can assist in the diagnosis of dementias even before the manifestation of clinical symptoms and can also improve prognostic predictions of future cognitive decline in persons with mild symptoms. Psychiatrists who perform forensic fitness for duty evaluations on high-functioning professionals (e.g. physicians, lawyers, judges, politicians, CEOs, pilots, etc.), face considerable ethics dilemmas related to determining what level of impairment is sufficient to opine that someone is no longer fit. That is, when considering a profession with unusually high work demands and serious potential consequences for impaired decision-making, the threshold for being unfit may be lower than for other less complex jobs. These high-functioning professionals may present with more subtle signs of cognitive impairment that neuropsychological tests do not detect. Psychiatrists performing these forensic assessments will also have the dilemma of determining how to utilize neuroimaging and biomarker data to inform their opinion of someone's fitness for duty and to estimate the progression of neurocognitive symptoms. In this presentation, Dr. Ryan Darby, a cognitive-behavioral neurologist, will review the current literature and scientific understanding of neurocognitive disorders as it relates to pathophysiology, symptoms, as well as the use of neuroimaging and biomarkers to make clinical

diagnoses and estimate prognoses. Dr. William Darby will outline fitness for duty forensic evaluations and the ethical challenges inherent for examining high-functioning professionals. Dr. Robert Weinstock will present dialectical principlism as an ethics model to resolve dilemmas in psychiatry by weighing and balancing competing considerations. Finally, Dr. William Darby will apply dialectical principlism to a hypothetical fitness for duty evaluation for a judge who has possible, subtle evidence of impaired judgment on recent rulings; the judge has only mild memory impairment on neuropsychological testing but has a PET scan positive for amyloid - highly suggestive of progression to Alzheimers dementia.

Holistic Approaches to Treating PTSD

Chair: Sudha Prathikanti, M.D.

Presenters: Selena Chan, D.O., Jessica R. Holliday, M.D., M.P.H., Christina Toutoungi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define key elements of an integrative psychiatry approach for treating PTSD; 2) Identify patients likely to be good candidates for an integrative psychiatry approach for treating PTSD; 3) Outline potential risks, benefits, and medico-legal issues associated with complementary therapies for PTSD presented in this workshop; and 4) Identify relevant licensing/professional safety boards for practitioners of any complementary therapies presented in this workshop

SUMMARY:

Post-traumatic stress disorder (PTSD) is a psychiatric condition with devastating effects on the lives of nearly 5% of U.S. adults annually [1]. Conventional psychotherapies and pharmacotherapies for PTSD may be clinically effective in only a subset of those seeking treatment [2, 3]; for example, in veterans with PTSD, up to two-thirds retain their diagnosis despite psychotherapy [4], and treatment-resistance is common[5]. Therefore, it is not surprising that many Americans with PTSD seek relief of symptoms with complementary and alternative medicine (CAM), even when scientific evidence of efficacy may be limited. In one national survey of individuals with diagnosed anxiety disorders, nearly 48% of those

with PTSD had used CAM such as acupuncture, mind-body therapies, spiritual practices or herbal products to treat their symptoms [6]. Similarly, in another survey, nearly 40% of veterans with PTSD used CAM to address emotional and mental problems [7]. In this context, it is vital for psychiatrists to understand strengths and limitations of using specific CAM therapies for PTSD. Moreover, while many psychiatrists may have heard of some complementary therapies for PTSD, they may feel uncertain about the "nuts and bolts" of potentially integrating such therapies into their own patient care. This workshop aims to strengthen the confidence of clinicians interested in developing and implementing integrative psychiatry treatment plans for PTSD. We first concisely review select CAM therapies for PTSD [8-12], and then using a case-based approach, we demonstrate to the audience key elements of incorporating these therapies safely into clinical scenarios to improve therapeutic outcomes in PTSD.

How Private Insurance Fails Those With Mental Illness: The Case for Single Payer Health Care

Chairs: Jon Wesley Boyd, M.D., Ph.D., Steven Samuel Sharfstein, M.D.

Presenters: Leslie Hartley Gise, M.D., Stephen Brooks Kemble, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session participants should be able to appreciate how the current health care system disproportionately penalizes psychiatrists and their patients.; 2) At the conclusion of this session participants should be able to understand how private insurers have adversely affected the practice of psychiatry.; 3) At the conclusion of this session participants should be able to appreciate the changes in mental health spending versus total health spending over the past thirty years.; and 4) At the conclusion of this session participants should be able to understand how a single payer national health program would offer universal coverage with higher quality and lower costs.

SUMMARY:

There is broad consensus that our health care system should provide quality, affordable health care for all. Despite increasing the number of insured individuals in the US, the ACA has failed to deliver improved outcomes, lower costs or universal coverage. This workshop will examine an alternative to our current system: a publicly-funded single payer national health program. Of the 30 million people who are uninsured at present, psychiatric patients are over-represented. And the data are clear that lack of insurance is linked to poor health outcomes as well as premature death. But merely having insurance is not enough to ensure access to needed care. Half of psychiatrists don't accept insurance primarily because of low reimbursement which is a barrier to access to mental health services. Additionally, insurers often set up roadblocks to obtaining care, such as requiring onerous prior authorizations prior to okaying inpatient stays or maintaining lists of in-network providers that are replete with wrong numbers or practices that aren't accepting new patients. Psychiatrists currently spend the highest percentage (over 20%) of their time on administration compared to other specialties, something that would likely improve were we to implement a single-payer system. With a single payer system, everyone would automatically be covered at birth, including psychiatric patients. And with private insurance mostly out of the picture, the profit motive would disappear and our patients would begin receiving needed care without the administrative and bureaucratic hassles seen in our current system. With single payer, a doctors' groups, like the APA, would be included in negotiations of standardized, reasonable rates so psychiatrists would be much more inclined to participate. The US spends twice as much on health care as other developed countries but we do not have the health care outcomes to justify that kind of spending because so much of our current spending goes to bureaucratic overhead, corporate profits, and executive compensation. Replacing our inefficient, multi-payer, private insurance system with a publicly-funded national health program, like an expanded and improved Medicare for all, would result in far fewer administrative and bureaucratic hassles for practitioners and also save at least \$400 billion annually by slashing administrative waste. The savings would be enough to cover all the uninsured

and upgrade benefits, including psychotherapy, for everyone else.

Imams in Mental Health: Caring for Themselves While Caring for Others

Chair: Rania Awaad, M.D.

Presenters: Farha Zaman Abbasi, M.D., Hooman Keshavarzi, Rami Nsour

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate understanding of the burden carried by Imams in providing a wide array of services to their community.; 2) Recognize the emotional stress faced by Imams whose official training falls short in the face of the continuously increasing demand for providing therapeutic services to their congregants.; and 3) Outline a basic framework for a collaborative care model that incorporates Imams in the mental health care of Muslim patients.

SUMMARY:

In the United States, the demand for mental health services is typically met by mental health professionals. In religious communities, however, faith leaders are often the first and sometimes only source of care sought by individuals to provide psychological services as diverse as marital, grief, family and spiritual counseling. In the Muslim community, the mental health support from faith leaders expands to also include Quranic recitation and supplication. Recent work has suggested that the official training of Muslim clergy offers little preparation in identifying mental health illnesses and counseling. This can lead to increased work-related emotional stress that may eventually lead to burnout. Recently, Khalil Center- a spiritual wellness center pioneering the application of traditional Islamic spiritual healing methods to modern clinical psychology- developed Mental Health First Aid trainings custom-tailored for Imams. They have successfully trained hundreds of Imams throughout the country using this novel model. This session will focus on understanding the integral and multi-faceted role an Imam plays and best practices in implementing a collaborative care model with Muslim faith leaders in order to provide the highest level of mental health care to Muslim communities.

Immigration Status as a Social Determinant of Mental Health: What Can Psychiatrists Do to Support Patients and Communities? A Call to Action

Chairs: Ruth S. Shim, M.D., M.P.H., Mallory Curran

Presenter: Sebastian Zavala

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how immigration status impacts mental health disparities for children, adolescents, and adults; 2) Identify key resources and community organizations available to support clinicians and their migrant patients; 3) Name at least three types of immigration relief for which behavioral health records are an essential element; 4) Describe at least three types of non-clinical support that psychiatrists can provide to migrants and communities; and 5) List the steps necessary to identify and engage in psychiatry-specific, immigration-related volunteer opportunities

SUMMARY:

Migrants of all kinds, including those with documented legal immigration status and those without, are facing a period of unprecedented uncertainty. Current U.S. immigration policies change at a rapid pace and are subject to intense administrative, congressional, judicial, and media review. Families have been separated at the border and continue to be impacted throughout the country as parents and other caregivers are deported, often with little warning. Psychiatrists may be seeing patients who have been traumatized (or re-traumatized) by recent events. Conversely, others may be seeing fewer migrant patients because of community fears and uncertainty around whether clinics are a safe space. Still other psychiatrists may be wondering for the first time how they can become engaged and advocate in their communities. This session will build upon a three-part online training series* on the social determinants of mental health and medical-legal partnership that all participants will be strongly encouraged to view prior to the Annual Meeting. This workshop will 1) address the link between U.S. immigration policy and structural racism/discrimination, two important social determinants of mental health, 2) review resources available to assist psychiatrists in

understanding the immigration landscape and supporting migrant patients, including immigration-focused medical-legal partnerships and online resources such as the APA Trauma Toolkit, and 3) allow participants in small group settings to review case studies and brainstorm opportunities for psychiatrists to support their own patients' applications for immigration relief and volunteer in support of migrant communities. To begin the session, an expert panel will summarize the concepts discussed in-depth in a proposed companion Annual Meeting session, "Engaging 'Patient-Centered Lawyers' as an Innovation to Promote Health Equity: Making the Case for Medical-Legal Partnership in Behavioral Health Settings," and then take a "deep dive" by exploring those concepts through the lens of immigration. The panel will include a review of a variety of legal and other resources available to help psychiatrists and their migrant patients, including online resources and opportunities to work in collaboration with lawyers who represent migrants. Next, participants will break into small groups, with each small group reviewing a different set of case studies, identifying about how psychiatrists could support the migrants and communities in the scenarios described, and reporting key takeaways back to the full group. The session will conclude with a Call to Action for psychiatrists and the APA to take a leadership role in increasing psychiatrist engagement in immigration-related advocacy and volunteerism. *The proposal for the associated three-part online training series is currently pending with the APA's Division of Education. Please contact Deputy Director Nina Taylor, MA for updated information.

Inequity by Structural Design: Psychiatrists' Responsibility to Be Informed Advocates for Systemic Education and Criminal Justice Reform

Chair: Sarah Yvonne Vinson, M.D.

Presenters: Nzinga Ajabu Harrison, M.D., Ruth S. Shim, M.D., M.P.H., Jeff Duncan-Andrade

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify inequities in the educational and criminal justice systems and their implications for development and population mental health.; 2) Describe aspects of the design of these

systems that create and perpetuate these inequities.; 3) Understand the social determinants of healthy growth, development and population mental health.; and 4) Articulate the rationale and describe potential strategies for the psychiatrist's role in addressing these issues through interdisciplinary advocacy efforts.

SUMMARY:

"Every system is perfectly designed to get the result that it does." – W. Edwards Deming Inequity is pervasive in American society – and growing. There are myriad negative effects for the growth and development of youth and, more broadly, for population mental health, and yet organized psychiatry has been conspicuously absent from discussions and advocacy initiatives targeting systemic inequity. Perhaps it is the emphasis on the medical model with inadequate emphasis on social determinants of health in medical and residency training. Perhaps it is poor awareness of inequity's multi-systemic drivers. Perhaps it is a perception that the status quo is fair or fundamentally unchangeable. Perhaps we just don't see it as our problem. In this workshop, presentations from four leaders with diverse perspectives will challenge attendees with information about inequities, the intentionality of their creation and perpetuation within American society, and the impacts on our patient populations and larger communities. This will be followed by a group discussion about barriers, opportunities and strategies for psychiatrists to use their unique skill sets and positions of privilege to advocate for change and to do so through interdisciplinary collaborations. Speakers include Jeff Duncan-Andrade, Ph.D., an Associate Professor of Raza Studies and Education Administration and Interdisciplinary Studies at San Francisco State University and co-author of *The Art of Critical Pedagogy: Possibilities for Moving from Theory to Practice in Urban Schools*; Ruth Shim, MD, MPH, Luke & Grace Kim Professor in Cultural Psychiatry at UC Davis and Director of Cultural Psychiatry and co-editor of *Social Determinants of Mental Health*; Nzinga Harrison, MD, Adjunct Faculty at Morehouse School of Medicine and Co-founder of Physicians for Criminal Justice Reform; and Sarah Y. Vinson, MD Associate Clinical Professor of Psychiatry and

Pediatrics at Morehouse School of Medicine and Senior Editor of OurselvesBlack.com.

Initiating Psychedelic Research and Critical Dialogue: Perspectives of Early Career Psychiatrists

Chair: Brian Scott Barnett, M.D.

Presenters: Jordan Slosower, M.D., M.Sc., Franklin King, M.D., Willie Siu, M.D., D.Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how contemporary clinical trials of psychedelics are being conducted, including components involving psychotherapy; 2) Utilize information learned from the presentation to initiate their own clinical or pre-clinical research into psychedelic treatments; 3) Understand the neuroscientific models and proposed mechanisms of action of psychedelics in the treatment of certain psychiatric conditions; 4) Understand contemporary attitudes of American psychiatrists regarding the potential use of psychedelics in psychiatry; and 5) Appreciate the experience of being treated with MDMA as a participant in a clinical trial

SUMMARY:

Recent years have seen a resurgence of both clinical and scientific interest in the use of psychedelic compounds (psilocybin, lysergic acid diethylamide, MDMA etc.) as treatments for mental illness. Numerous contemporary studies have demonstrated preliminary efficacy in addressing a variety of psychiatric conditions, including depression, PTSD, and anxiety and substance use disorders. Given the increased attention on this area of investigation, many young mental health practitioners and researchers are looking for ways to become involved. However, there remain significant scientific, political, ethical, and legal obstacles to conducting research on psychedelic treatments. In this session, presenters will discuss their experiences designing, initiating, and conducting research involving psychedelic treatments and provide a multifaceted view into how such research is conducted. Dr. Barnett will discuss the results of a survey he conducted of American psychiatrists to elicit their views on psychedelic treatments and their knowledge of psychedelic compounds. Dr. King will then review current neuroscientific understandings

behind the mechanisms of action of psychedelics and potential areas for future research. Dr. Slosower will discuss his experience designing and initiating an ongoing study investigating psilocybin-assisted therapy in the treatment of major depressive disorder, as well as his involvement in developing an interdisciplinary psychedelic science interest group at a major academic medical center. Dr. Siu will discuss his experience as a sub-investigator and study therapist in an ongoing randomized, double-blind, placebo controlled trial assessing the efficacy of MDMA-assisted psychotherapy in the treatment of posttraumatic stress disorder. He will also discuss his experience taking MDMA in a clinical trial, as part of the therapist-training program for MDMA therapists. Throughout each segment, the presenters will detail how they became involved in this area of research, discuss obstacles they faced, and provide recommendations from their experience to audience members interested in conducting investigations of their own. The presenters will enhance attendee participation through asking questions of the audience pertaining to the session content. The session will conclude with a question and answer session to invite and facilitate further discussion and allow more specific questions from audience members regarding the findings and logistics of the presenters' research, and other related topics.

Innovative Leadership in Action: Chief Residents of Diversity and Inclusion in Graduate Medical Education

Chair: Robert Mark Rohrbaugh, M.D.

Presenters: Jessica Elizabeth Isom, M.D., M.P.H., Kristin S. Budde, M.D., M.P.H., Amalia Londono Tobon, M.D., Natalie Lastra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the evolution of Yale Psychiatry's Chief Resident of Diversity & Inclusion position; 2) Illustrate three initiatives piloted by the Chief Resident(s) of Diversity & Inclusion that participants may use at their own institution; 3) Provide ways to involve stakeholders in fostering diversity, equity, and inclusion in graduate medical education; 4) Understand the challenges and lessons learned from establishing this

new initiative, and consider challenges that participants may encounter at their own institutions; and 5) Provide possible solutions to challenges that participants may face in implementing novel diversity efforts at their institutions

SUMMARY:

Although most would agree that issues of diversity, equity, and inclusion are important to education, it can be difficult to take concrete steps to foster diversity. Maintaining an environment that is inclusive and supportive of diversity can be difficult. Programs have tried to address this by using Title IX, ombudspersons, chief residents, and program directors to address overt discrimination or other barriers to diversity. At the larger institutional level, universities and medical schools have created positions such as deans for diversity. However, after evaluation of psychiatry residents' needs at Yale, there was a request for an institutionalized, and consistent group of individuals who could provide support and assistance to residents and faculty on issues related to diversity from the resident perspective. In our program's on-going assessments of needs, residents report encountering microaggressions, implicit biases, and other subtler forms of discrimination that affect their well-being and productivity. The Chief Resident of Diversity & Inclusion position in the Department of Psychiatry at the Yale School of Medicine is an exciting and challenging opportunity to effect change within the Department. The position was created and pitched by residents interested in expanding upon existing departmental efforts to support diversity and model inclusion. There had been no formal role for residents interested in the work prior to the acceptance of the proposal to designate a chief resident with protected time and specialized mentorship. The vision for the role is that appointed residents will help assess, develop, and cultivate an environment that is equitable, inclusive and supportive of diversity for all trainees, particularly for underrepresented minority trainees as well as for individuals who may experience bias on the basis of gender, ethnicity, gender identity, sexual orientation, age, and ability. The Chief Resident(s) work to promote diversity and inclusiveness will facilitate all residents utilizing their unique strengths to further the department's mission. Specific areas

for resident driven efforts included bringing leadership, vision, integrity, and a team-oriented philosophy to diversity and inclusion efforts for trainees in the department in areas such as recruitment, selection, and appointment of residents and trainees. Responsibilities also include the implementation of workshops, presentations, learning modules and other strategies that promote diversity, equity, and inclusion. The workshop will expand upon the background context for the role's creation and guide participants towards an understanding of the unique role trainees can play in diversity and inclusion efforts. The workshop will also provide scaffolding for program leadership and residents to begin considering the utility of a similar role within their programs. We will end with a panel discussion and Q&A to further explore the challenges and triumphs of the work.

Innovative Systems to Address New Challenges in College Mental Health

Chair: Doris M. Iarovici, M.D.

Presenters: Barbara Sue Lewis, M.D., Ayesha K. Chaudhary, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify three innovative systems of care which have increased university student access to and utilization of mental health services.; 2) Demonstrate an understanding of critical elements necessary for comprehensive and consistent assessment and treatment of students with ADHD or attentional complaints.; and 3) Identify strategies to better meet the needs of students who have traditionally underutilized campus psychiatric services, including students of color, international students, and first gen students.

SUMMARY:

What has been described as a mental health crisis among university students is likely a combination of increased prevalence and severity of psychiatric illness, and developmentally normal emotional distress that universities are unsure how to address. Although mental health services on campus have expanded significantly over the last decade, demand continues to outstrip resources. Increasingly diverse student populations require revitalization of existing

models, to appropriately respond to current needs. A national survey showed college students of color are half as likely as white students to seek help, despite reporting greater emotional distress during freshman year and experiencing depression and anxiety at similar rates. International students, first gen students, LGBTQ students, and students with pre-existing disabilities also comprise larger percentages of university populations, and may be more reluctant to access traditional models of care. Certain chronic diagnoses, such as ADHD, more prevalent now among university students, require ongoing frequent visits. And though undergraduate distress has previously commanded more scholarly and media attention, a recent study shows that graduate students are more than six times as likely to experience depression and anxiety as the general population. Student activists have been increasingly vocal in their demands for improved rapid access to services, complaining of long wait times to first appointments. As we develop a better understanding of the diversity of populations that comprise university samples, we must also craft new systems to meet their needs. In this session we will present several innovative approaches piloted at a couple of universities to address improved access to psychiatric services, with a focus on equity and provision of evidence-based treatment. Faced with the growing demand for stimulant medication, and aware of national concerns about medication diversion, in 2017 Harvard's CAMHS developed a systematic protocol for ADHD assessment and treatment, to ensure appropriate use of clinical resources and more uniform assessment practices. In addition to a streamlined evaluation process, we achieved a reduction in number of prescriptions for stimulants. In spring of 2018 Harvard instituted a rapid triage system which met the goal of assessing 80% of students within 48 hours of their first contact with the system. We will present data on ongoing efforts to match student need to appropriate care, with attention to both student and staff satisfaction. A walk-in model instituted at Duke in 2018 addressed a 17% greater utilization rate than in previous years, and demonstrated a significant increase in clinical services utilization by students of color. We will discuss additional factors that likely contributed to these changes, including

diversification of staff and training initiatives focused on race and equity.

Innovative Tools for Population Neuroscience in the Age of Big Data

Chair: Wesley K. Thompson, Ph.D.

Presenters: Steven Heeringa, Ph.D., Kenneth Sher, Ph.D., Hermine Maes, Ph.D., Michael Neale, Ph.D., Hauke Bartsch, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the population design of ABCD and how to make valid population-level inferences with its data.; 2) Make reasoned judgments regarding the validity of personality and psychopathological measures for longitudinal analyses of ABCD data.; 3) Apprehend the population genetic aspects of ABCD, how to use these to parse variation in neurodevelopmental outcomes due to genes and shared and unique environment, as well as gene by environment inte; and 4) Grasp the design and structure of the ABCD study, how to access the data on NDA, and have facility in the use of an informatics and analysis tool (DEAP).

SUMMARY:

This course explores important topics in population developmental neuroscience in the age of Big Data. Neurodevelopmental studies are becoming big in two senses, both of which make analysis challenging. First, the sample size is growing ever larger. Second, the number of domains of measurement (genetics, brain imaging, environment, ecological momentary assessment, biospecimens, structured interviews, self-report, and so forth) and the number of measures per domain are growing at an even more rapid rate. Efficiently utilizing these data to address scientific questions can require a daunting level of expertise, ranging from knowing how to download and navigate datasets with thousands of subjects and hundreds of thousands of measures, to how to assess the validity and relevance of measures for a given scientific application, to what questions and hypotheses can potentially be fruitfully addressed from a given study design, to what population is it valid to make inferences about with the data at hand. These substantial challenges and

unprecedented scientific opportunities are exemplified by the Adolescent Brain Cognitive Development (ABCD) study. The ABCD study is a multi-site longitudinal study supported by the National Institutes of Health to increase our understanding of how diverse experiences during adolescence interact with changing biology to influence brain, cognitive, and social/emotional development. To date, the ABCD consortium has studied over 11,000 9 and 10-year-old typically developing children using a comprehensive battery of behavioral assessments of mental health, substance use, cognitive function, social function, and personality as well as brain imaging. This course will give an overview of crucial issues in Big Data developmental neuroscience as exemplified by the ABCD study from study leaders. Course topics include informatics and statistical analyses, assessment of longitudinal personality and psychopathology measures, population-level inferences, and assessing the relative impact of genetics and environment on developmental trajectories. Specific skills expected to be gained: 1) how to assess the validity of specific personality and psychopathological longitudinal outcomes for a given scientific question; 2) methods to ensure analysis results accurately reflect the population as a whole; and 3) how to assess the relative impact of genetics and environment on neurodevelopmental trajectories. All of these topics will be presented with concrete examples taken from analyses of the baseline ABCD data. The fourth and final skill will be to 4) learn how to access and navigate the publicly-available ABCD data, including imaging and genetics, and how to explore and analyze these data in the ABCD Data Exploration and Analysis Portal (ABCD DEAP, hosted on the NIMH Data Archive along with the ABCD data themselves). All methods described in the course will be implemented on DEAP and hence usable for course participants going forward.

International Medical Graduates and a Successful Career as a Psychiatrist in the United States

Chair: Rajesh R. Tampi, M.D., M.S.

Presenters: Juan Joseph Young, M.D., Silpa Balachandran, M.D., Thien Chuong Richard Ly, M.B.B.S.

Discussant: Antony Fernandez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To describe who in an IMG; 2) To discuss how an IMG can obtain a residency position in psychiatry in the US; 3) To define the pathways to successful completion of psychiatry residency training in psychiatry in the US; 4) To elaborate on ways to obtain a competitive fellowship position in psychiatric sub-specialties; and 5) To enumerate ways in which an IMG can develop a successful career as an attending psychiatrist

SUMMARY:

In this symposium we will define who is an International Medical Graduate (IMG) and discuss the role of the IMGs in care of individuals with psychiatric illness in United States. We will enumerate the unique challenges faced by IMGs while training and working in the United States. We will describe strategies that will enable IMGs to obtain and successfully complete psychiatry residency training in the United States. We will then discuss successful strategies to obtain competitive fellowship positions in sub-specialties in the United States. Finally, we will enumerate strategies on who an IMG can integrate into the mainstream psychiatry workforce as an attending psychiatrist. Greater number of psychiatrists will enable improved access to care for the older adults with mental illness. It will also maintain the success of APA as the premier national organization that safeguards the interests of the psychiatry in the United States.

International Medical Graduates and Psychiatry Residency Training in the United States: A Primer

Chair: Donna Marie Sudak, M.D.

Presenters: Ali Ahsan Ali, M.D., Dhruv Gupta, M.D., Ritesha S. Krishnappa, M.D., Robert J. Olson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To appreciate the historical role of diversity in psychiatry; 2) Identify applicant specific barriers behind the declining match rate of international medical graduates; 3) Identify residency program specific barriers behind the declining match rate of international medical graduates; 4) Identify strategies to overcome and

address these barriers proactively; and 5) Navigate towards a successful Match

SUMMARY:

The field of Psychiatry and human behavior by its very nature is as diverse as the population it caters to. Over the course of centuries, great strides have been made to further a better understanding of psychopathology and how human suffering can be minimized. As a field, we have evolved from physical confinements, to an era of lobotomies, to the depths of psychoanalysis, and recently to an appreciation of the underlying neurophysiological processes at play at the level of the brain and the mind. As a discipline, Psychiatry has and continues to stand on the shoulders of intellectual giants - who in addition to mental prowess - share another thread in common, diversity. A German psychiatrist gave us a method to classify mental illness half a century ago; an Austrian Neurologist introduced us to the vagaries of the mind, and a Swiss Psychiatrist helped us look beyond the binaries to the dynamic biopsychosocial model used to date. Over the last three decades, three presidents of the American Psychiatric Association have been international medical graduates (IMG). Similarly, several IMGs continue to make outstanding contributions in the United States (US), serving as prolific leaders in the field. Despite the vast contribution by IMGs, the percentage of IMG physicians matching into Psychiatry residency programs has steadily declined by half over the past decade (1). The prevailing impression at play appears to be deficiencies in IMG training when compared with the training of American medical graduates (AMGs). Various barriers have been implicated, including but not limited to: suboptimal exposure to psychiatry during medical schooling; lack of familiarity with the U.S healthcare system; impediments to assimilate with the American culture and the stress of immigration (2,3). Though the aforementioned concerns hold merit, they should not be reasons barring the admission of IMGs into Psychiatry as they can be overcome. As a first step, an appreciation of these barriers can empower applicants to address them to increase their competitiveness. It will be of help for training programs to develop an understanding that such barriers – which are often minor in contrast to the potential of IMGs – can be bridged during residency

training. Using specific case examples, our session will introduce participants to established and perceived barriers from the perspective of training directors and IMG applicants. Our panel, comprised of three residency training directors (including the president of American Association of Directors of Psychiatric Residency Training) and current IMG residents will identify strategies to overcome these barriers. Our panel will engage participants in an interactive discussion on varied topics, including: factors that program directors consider when interviewing/ranking applicants, determining a “good fit,” pre-match offers, and ultimately, navigating towards a successful match.

Interventions to Address Opioid Addiction

Chair: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate the prevalence of and recent trends in opioid misuse and OUD in the United States.; 2) Have a deeper understanding of evidence-based interventions for preventing and treating opioid misuse and OUD.; and 3) Understand emerging research opportunities for addressing opioid misuse and OUD.

SUMMARY:

The year 2017 saw a record 47,000 deaths from opioid overdose in the United States, and currently more than 2 million people across the nation suffer from opioid use disorder (OUD). Although there are effective treatments for OUD, only a fraction of people with the condition receive them, and of those, less than half receive one of the three FDA-approved pharmacotherapies. In April 2018, the National Institutes of Health (NIH) launched the HEAL (Helping to End Addiction Long-termSM) Initiative, an aggressive, trans-agency effort to speed scientific solutions to stem the national opioid public health crisis. Through the HEAL Initiative, NIDA is supporting research to expedite the development of therapies to treat OUD and reverse overdose, test innovative ways to identify and treat newborns exposed to opioids and track their long-term development, and test the integration of promising prevention strategies and evidence-based treatment for OUD into multiple

settings. This presentation will address the ongoing opioid crisis in the United States; review evidence-based interventions for preventing and treating opioid misuse and OUD; discuss the critical role of psychiatrists and other healthcare providers in implementing these interventions and in combatting the stigma associated with OUD and other substance use disorders; and highlight emerging areas of research that will be necessary to end addiction long-term.

Is There a Doctor on Board? Getting You Prepared for the Most Common Medical and Psychiatric Emergencies on Commercial Airlines

Chairs: Rachel Lipson Glick, M.D., Michelle B. Riba, M.D., M.S.

Presenters: Steven G. Dickstein, M.D., Debra A. Pinals, M.D., Karen Lommel, D.O., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the roles of flight crew, medical ground support and medical passenger volunteers in responding to an in-flight medical emergency; 2) Know the common medical/psychiatric emergencies seen on commercial airline flights; and 3) Describe the legal and ethical issues relevant to a medical volunteer on a commercial flight

SUMMARY:

This submission is a repeat of our successful and oversubscribed workshop from last year's annual meeting. In-flight medical and psychiatric emergencies are fairly common and volunteer medical professionals are often asked to provide care, with lack of guidelines and standardized processes. Flight physiology and different conditions make flying difficult, and even hazardous, for some patients with pre-existing medical and psychiatric conditions. When there is a request for a doctor on board, psychiatrists often feel uncomfortable responding. This workshop will review the common medical and psychiatric emergencies and symptom clusters seen on flights and provide a general approach to these situations. We will also review when you should and should not respond to a request for a physician's help, what to do if there are other clinicians on board, what you might encounter

in terms of equipment and medications, how to get additional help, and how to interact with the inflight crew.

Latina/Hispanic Women and Mental Health: Current Issues and Reason for Hope

Chair: Esperanza Diaz, M.D.

Presenters: Andrea Diaz Stransky, M.D., Tatiana A.

Falcone, M.D., Pamela Carolina Montano, M.D.

Discussant: Ruby C. Castilla Puentes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Examine the complexities and intersections of multiple factors e.g., socioeconomic status, and cultural background, and their impact on mental health in Latino/Hispanic Women.; 2) Evaluate the long term impact of childhood abuse on a group of Latino/Hispanic Women.; and 3) Recognize the importance of sociocultural context and variables in the psychiatric diagnostic approach aimed at improved outcomes in mental health care of Latino/Hispanic Women

SUMMARY:

Given that health and illnesses are experienced differently by men and women, an inclusive understanding of mental health issues must take into account gender differences. Research on racial and ethnic health-care access and utilization constantly identifies Latinas as one of the most disadvantaged ethnic groups. Using measures such as usual source of care, health insurance coverage, and the quality of care received, barriers for Latina women (Latinas) are readily identified. As a fast-growing demographic, it is important to address the challenges and barriers that may affect the quality of mental health and mental health care among Latina women. The position of women and the impact on their mental health status will be considered against the backdrops of their changing economic, political and professional standing. This symposium focuses on existing studies of mental health and health-care data of Latinas. 1. An examination of the mental health of immigrant mothers. 2. The deficits with regard to gender parity in the current academic and clinical psychiatric landscape and 3. Trauma and its impact in the mental and physical health of Hispanic/Latina women: issues to consider when

treating this population. At the end, the discussant will summarize the main topics and the panel will be open for questions, answers and comments from attendees regarding the material presented. Ongoing efforts and interventions to enhance the participation of Latinas on professional, and political levels are necessary. This symposium is in collaboration with the APA Hispanic Caucus and the American Society for Hispanic Psychiatry

Leadership in Psychiatry: Conflict Management, Communications, and Negotiations

Chairs: Amanda Degenhardt, M.D., Marlon Danilewitz, M.D.

Presenters: Michael Paul Butterfield, Imbenzi George, Ph.D., M.A., Kathryn Skimming, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop insight into one's own leadership style.; 2) Learn negotiation strategies and practice utilizing them to collaborate successfully with individuals of varying leadership styles.; 3) Describe barriers to resolutions and additional strategies to resolve conflict situations.; 4) Employ e-communication and e-planning (e.g. emails, online polls) to improve effectiveness and efficiency of leading a group.; and 5) Compare different skills required to facilitate strategic conversations in different settings (e.g.in-person and long distance meetings).

SUMMARY:

There is growing recognition of the importance of physician leadership in healthcare¹. At the same time, becoming an effective leader requires significant training. While there are leadership educational opportunities for physicians, there is a paucity of leadership opportunities in psychiatry training. The workshop aims to provide medical students, residents/fellows, and early career psychiatrists with an introduction to conflict management, basic negotiations skills, and effective digital communication in a leadership role. During the first part of the session we will discuss different leadership styles and utilize a real-life healthcare management scenario to allow participants to further develop their management skills. Participants will then break up into different groups

and be assigned a particular role for the purpose of the conflict negotiations. After the negotiations, we will examine how each individual group was able to come to a decision and discuss the successes and challenges that arose. We will review additional conflict resolution strategies that can be applied in future negotiation settings. This interactive workshop will help to promote insight into one's own leadership style to assist individuals in conflict management and negotiations. During the second part of the session we will use the earlier scenario as a platform to focus on successful e-communication as a tool to engage, motivate and facilitate change when working with others.² In the age of technology, leaders in medicine are often global leaders, virtually managing teams through the utilization of email communications, web polls, and tele- or video-conferencing.³ Whether planning a follow-up meeting or organizing a multi-site working group, we will teach participants how to be effective leaders using different e-communication styles to facilitate positive interpersonal relationships and gain strong collective opinion.

Leveraging Technology in Psychotraumatology

Chair: Eric Vermetten, M.D., Ph.D.

Presenters: Isaac Galatzer-Levy, Skip Rizzo, Ph.D., Marieke J. van Gelderen

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To educate the audience on the potential and risks of machine learning and artificial intelligence for the prediction and classification of psychiatric risk.; 2) To provide information and access to newly developed predictive tools for posttraumatic stress risk.; 3) To learn how mobile apps can be used to detect those at risk for developing PTSD after a terrorist attack or other mass traumatic events.; 4) To understand the issues involved in the design, development, implementation, and evaluation of virtual reality environments for use in PTSD assessment and intervention.; and 5) To understand the framework of a virtual reality based and motion-assisted intervention and describe how this therapy can be used for veterans with treatment-resistant PTSD.

SUMMARY:

Novel technologies are rapidly entering clinical arenas and provide possibilities for mental health practices and Posttraumatic Stress Disorder (PTSD) in particular. After an initial burst of applications, we are entering a stage of robust research on technological advancements and their translation into clinical practice. In this session we focus on the domain of psychotraumatology and present current cutting-edge technologies. We will discuss technological innovations that can aid prevention, prediction and increasingly engaging and effective treatments for PTSD. Dr. Galatzer-Levy will present on the framework for machine learning predictive algorithm construction for clinical risk. To demonstrate these principles, he will present on his labs recent work, the first high accuracy predictive algorithm for posttraumatic stress prediction in the immediate aftermath of a traumatic event based on biological and social determinants, validated across 2 large populations of emergency medical patients. He will discuss new directions in machine learning/artificial intelligence for remote measurement and prediction of clinical risk through cell phone technology and its relevance to PTSD prediction and prevention. Dr. Zohar will present the mobile Ifeel PTSD app, which passively collects continuous biological, behavioral and other smart phone based markers. He will discuss how apps can be used in the context of terrorist attacks as a tool to detect and monitor those individuals who are not recovering well during the aftermath. He will present data from a study in which the Ifeel app was used for veterans with PTSD. Dr. Rizzo will present on the use of Virtual Reality (VR) in PTSD treatment. He will discuss how VR can increase efficacy of treatment and how it can be used to address barriers to care by promoting the acceptability of seeking treatment for PTSD. He will present results from a recently completed large randomized controlled trial comparing VR exposure therapy with prolonged exposure. Following a clear detailing of these treatment options during the informed consent process, participants were asked which treatment they would prefer to be assigned to, if in fact they had a choice. Drs. van Gelderen will present an innovative therapy, 3MDR, which combines VR with walking and delivers personalized multi-sensory input. This intervention specifically aims to decrease avoidance and increase engagement during

treatment, which will be illustrated with short videos of patients and the intervention. The efficacy of this intervention has been studied for veterans with treatment-resistant PTSD in a randomized controlled trial, of which the outcomes will be presented. The session will be concluded with a guided discussion on the value of leveraging these technologies in psychotrauma research and clinical care. The presenters will invite you to think of ways in which these can be applied in the clinical practice of PTSD prevention, detection and treatment.

Making Your Presentation More Interactive: The Better Way!

Chair: Jonathan S. Davine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the superiority of interactive teaching versus the traditional didactic model in changing physician behaviour.; 2) Use and participate in different group activities that enhance interactive group teaching.; and 3) Maximize the use of commercial film clips and audiovisual patient encounters to enhance group teaching.

SUMMARY:

Educational literature has shown us that traditional didactic presentations usually are not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we look at factors that can enhance interaction, including room arrangements, proper needs assessment, and methods to facilitate interactive discussions. We will start the workshop with a needs assessment, which will involve the active involvement of the participants. We will then have a didactic component discussing some of the literature in this area. The group will then have an interactive component, which will involve participating in different group activities, such as "Buzz Groups" and "Think-Pair-Share", and "Stand Up and Be Counted", which enhance small group interaction. The use of commercial film to enhance educational presentations has been coined "cinemeducation". We will discuss techniques to help use film as a teaching tool. We will also comment on how to

maximize the use of audiovisual tapes of patient encounters as a teaching tool. This will also involve direct viewing of an audiovisual tape to illustrate these principles. We will end with a summary and get feedback from the group as to their reaction to these methods of teaching.

Medical Cannabis: What Every Psychiatrist Should Know

Chair: David Alan Gorelick, M.D., Ph.D.

Presenters: Kevin Patrick Hill, M.D., M.H.S., Arthur Robinson Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1) Understand the differences between federal law and the various state laws governing medical cannabis; 2) 2) Be familiar with the clinical indications for medical cannabis and the levels of scientific evidence supporting them; 3) 3) Recognize the different clinical effects associated with various cannabis routes of administration and THC and cannabidiol concentrations; 4) 4) Identify potential patients for whom medical cannabis might be indicated or contraindicated; and 5) 5) Be familiar with potential public health consequences of medical cannabis use

SUMMARY:

Use of cannabis for medicinal purposes (medical cannabis) has a centuries-long history in the US and throughout the world, but has been illegal in the US at the federal level since 1937. Cannabis and all cannabinoids are classified in Schedule I of the Controlled Substances Act (CSA), meaning that they are considered to have a “high potential for abuse,” “no currently accepted medical use in treatment,” and “a lack of accepted safety for use” (21 U.S. Code § 812). In contrast, state-level interest in medical cannabis has been growing over the past 2 decades. As of August, 2018, 31 states, the District of Columbia, Puerto Rico, and Guam have made medical cannabis legal under state law, although not all programs are operational. Another 15 states have laws allowing use of cannabidiol (or “low-THC” cannabis) to treat seizures. However, most US physicians, including psychiatrists, receive little or no training about medical cannabis. Thus, they have inadequate knowledge and expertise to respond

appropriately to patients who are interested in medical cannabis, to recommend it to patients who might benefit, or to discourage its use by patients for whom it would not be therapeutic. Our session will fill this knowledge gap through interactive presentations by 3 nationally known experts. During our session, presentations will serve as a focus for discussion among presenters and attendees, culminating in a discussion of presented case vignettes and then general discussion. Our session will describe the difference between “prescribing” a medication under federal law vs. “recommending” or “authorizing” medical cannabis under state law, the major medical and psychiatric conditions for which medical cannabis can be recommended (most commonly pain, cancer, multiple sclerosis or muscle spasm, seizures, nausea and vomiting, HIV/AIDS, glaucoma, post-traumatic stress disorder, agitation associated with Alzheimer’s disease), the current scientific evidence supporting those indications, major side-effects associated with medical cannabis (e.g., dizziness, dry mouth, fatigue, drowsiness, euphoria, disorientation, confusion, loss of balance, motor incoordination, hallucinations), and potential public health consequences (e.g., increased motor vehicle accidents, diversion and increased misuse of cannabis, decreased use of opiate analgesics). Our session will also review the practical clinical pharmacology of medical cannabis, including the advantages and disadvantages of various routes of administration (smoked, inhalation of vapor, oral), cannabis strains with varying concentrations of THC, cannabidiol (CBD), THC:CBD ratios, and various doses. Attendees will then apply this information to discussion of several case vignettes of patients interested in taking medical cannabis.

Medical Marijuana for Psychiatric Disorders: Is It High Time or Half-Baked?

Chairs: Rajiv Radhakrishnan, Deepak D'Souza, M.D.

Presenters: Deborah Hasin, Ph.D., Michael Van Ameringen, M.D., Alan Ivan Green, M.D., Robin M. Murray, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an overview of marijuana, the different constituents in marijuana and the effect of marijuana on the endocannabinoid

system; 2) Provide an update on the epidemiological evidence for the effects of marijuana on psychiatric outcomes and motor-vehicle accidents; 3) Provide an update on the effects of marijuana on cognition and brain reward circuitry; 4) Provide an update on the evidence for the use of medical marijuana in anxiety disorders and PTSD; and 5) Provide an update on evidence for harmful and beneficial effects of various cannabinoids in psychotic disorders

SUMMARY:

As of July 2018, “medical marijuana” has been approved in 31 states, the District of Columbia, Guam and Puerto Rico in the US. Marijuana however remains a Schedule-1 drug per the US Drug Enforcement Administration (DEA). Nevertheless, today the market-place is flooded with over 2500 “strains” of the marijuana plant and marijuana-infused products (including edibles, concentrates, dabs, waxes, oils, vaping fluids). These products are not regulated by the Food and Drug Administration (FDA) and don’t meet the FDA standards for approval of other medications, although the product labels accompanying these products may appear similar to that seen with pharmaceutical medications. One of the chemical constituents of marijuana, cannabidiol (CBD) was approved by the FDA for the treatment of treatment of seizures associated with two rare and severe forms of epilepsy, Lennox-Gastaut syndrome and Dravet syndrome. Some evidence supports the use of “medical marijuana” for specific medical conditions. However, evidence supporting the beneficial effects of marijuana for psychiatric conditions is of low quality and furthermore, individuals with certain psychiatric disorders may be at greater risk for adverse effects. This presents a challenge for physicians treating patients who use “medical marijuana” and tout the benefits of the products based on manufacturer’s product labels. Furthermore, it is possible that psychiatrists encounter patients who are using medical marijuana for a psychiatric indication or may be co-managing a patient who is receiving medical marijuana for a no psychiatric (medical) condition. This invited Forum at the APA will provide practitioners with an update on the status of ‘medical marijuana’ as a treatment for psychiatric disorders. The faculty will provide an

overview of marijuana, the different constituents in marijuana (including THC and CBD), and the effect of marijuana on the endocannabinoid system. We will then discuss the epidemiological evidence for the effects of marijuana on psychiatric outcomes, including data on risk of psychiatric disorders and on rates of motor-vehicle accidents. Faculty will then provide an update on the effects of marijuana on cognition and brain reward circuitry. This will be followed by an update on the evidence for the use of medical marijuana in anxiety disorders (including PTSD); and evidence for the beneficial effects of CBD and harmful effects of high-THC marijuana in schizophrenia. We will include live audience polling to make it interactive and generate discussion.

Minimizing Risk in Psychiatry

Chair: Moira Wertheimer, Esq., R.N.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

At some point during a psychiatrist's career he will likely be involved in a lawsuit-- either as a defendant, a treating physician or as an expert witness. If a psychiatrist is involved in a lawsuit as a defendant, the impact can be significant and can affect the psychiatrist for 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.

Misogynist Ideology and Involuntary Celibacy: Prescription for Violence?

Chair: Kayla L. Fisher, M.D., J.D.

Presenter: Shree Nitya Sarathy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review history of the online subculture, Incel; 2) Evaluate the current beliefs promoted by Incel.; 3) Discuss recent violent acts attributed to Incel.; 4) Examine the interplay between mental illness and this online hate communities.; and 5) Consider possible treatment options for patients affiliated with the Incel subculture.

SUMMARY:

The advent of the Incel online subculture can serve as a breeding ground for violence. Those struggling to find a romantic or sexual partner pose the greatest risk of becoming attached to Incel ideology. Incel forums provide a platform for resentment, self-pity, misogyny, a sense of entitlement to sex, and the endorsement of violence against sexually active people. Psychiatrist need to have an understanding of what such groups believe and promote, as well as violent acts that may flow from an affiliation with this group. Vulnerable patient populations need to be identified and treatment options explored to address the underlying mental states. In this session, we will review the history of Intel and evaluate the current beliefs espoused. The various recent mass murders and violent acts attributed to affiliations with Incel will be reviewed, along with an examination of the underlying mental health issues and treatment considerations.

Moving Forward: The ABPN Continuing Certification Pilot Program

Presenters: Joan M. Anzia, M.D., Christopher R. Thomas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learners will understand the educational principles underlying the creation of the MOC Pilot; 2) Learners will understand the basic structure of the MOC Pilot Project and how to participate.; and 3) Learners will describe some of the initial challenges in article selection and question-writing as the Pilot has been rolled out.

SUMMARY:

The ABPN has initiated a 3 year Pilot Project for Continuing Certification (MOC) in January 2019 as an alternative to the 10 year secure multiple choice exam. This Pilot Project, approved by the ABMS, consists of reading key journal articles in peer-reviewed publications and answering 5 multiple-choice questions following each article. A total of 40 available articles cover 10 major content areas in psychiatry; each Pilot participant must read, and pass 4/5 questions on, a total of 30 articles during the Pilot. Participants can take as much time as desired to read the articles and complete the online questions, and it is an "open book" assessment. The Pilot went live in January 2019; we will present some of the initial feedback from participants and some of the changes we have made to address the feedback.

New Psychiatric Perspectives on an Old Challenge: Narcissistic Personality Disorder

Chairs: Elsa Ronningstam, Ph.D., John Gunder Gunderson, M.D.

Presenters: Elsa Ronningstam, Ph.D., Royce J. Lee, M.D., Lisa J. Cohen, Ph.D., Igor Weinberg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe phases of change observed in long-term successful psychotherapies with patients with NPD; 2) Demonstrate awareness of NPD's relevance to psychiatry's clinical research and neurobiological traditions; 3) Discuss the impact of childhood trauma and maladaptive childhood attachment relationships on narcissistic personality traits in adulthood; and 4) Identify candidates for effective intervention strategies in treatments of NPD patients

SUMMARY:

The considerable literature about Narcissistic Personality Disorder (NPD) has been dominated by psychoanalytically-based perspectives on its psychological abnormalities and their environmental origins. The relevant literature about NPD's treatment has similarly been dominated by psychotherapeutic reports of the obstacles and challenges psychotherapists encounter. This symposium will introduce some recently emerging perspective that rely on empirical methods. Each presenter will report on their research. Dr.

Ronningstam will report findings on phases on change derived from the first case series (N=8) of successfully treated NPD patients. Dr. Lee will report on his pioneering explorations into the neurobiological abnormalities associated with NPD. Dr. Cohen will address the childhood antecedents of NPD, specifically assessing different types of childhood trauma and insecure attachment styles. She will also explore the psychological mechanisms by which disadvantageous childhood experiences may contribute to NPD traits in adulthood. Dr. Weinberg examines intervention strategies in detailed case reports (n=8) from the McLean Study of Treatment of NPD. Findings will be discussed in light of the literature on treatment of NPD. Altogether, those attending this symposium will appreciate the knowledge that can be acquired by using research methodologies to study NPD.

No Blacks, Fats, or Femmes: Stereotyping in the Gay Community and Issues of Racism, Body Image, and Masculinity

Chair: Kenneth Bryan Ashley, M.D.

Presenters: Murad Khan, B.A., Paul Emmanuel Poulakos, D.O., Alex Arash Nourishad, M.D.

Discussant: Kenneth Bryan Ashley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand some of the potential causes for mental health disparities in gay men; 2) Conceptualize racism within the gay male community through both minority stress and intersectionality frameworks; 3) Understand how “objectification theory” accounts for body image dissatisfaction among gay men; and 4) Demonstrate an awareness of the emphasis on masculinity in men who have sex with men

SUMMARY:

Psychiatry has steadily started to frame the mental health disparities experienced by gay men as related to homophobia rather than something intrinsic to being gay. However, mental health disparities within lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities necessitate closer examination of how homophobia interacts with other forms of oppression. In the gay male community in particular, issues of racism, body

image, and concepts of masculinity often function to exert deleterious effects. The mental health effects of homophobia and racism on LGBTQ people and people of color respectively have been well documented. LGBTQ people of color experience both forms of oppression. Discriminatory experiences have been shown to impact levels of depression, anxiety, and suicidal ideation in gay men of color. In this workshop these issues will be discussed as have been conceptualized using the minority stress model, but also using the framework of intersectionality. An intersectional lens would posit that different racial groups experience homophobia and racism in ways that are not simply additive. The framework or model used to conceptualize the issue will have implications for both treatment of the individual and structural interventions. Gay men have been shown to exhibit higher body image dissatisfaction, self-objectification, body shame, and drive for thinness than heterosexual men. These factors have been associated with disordered eating patterns, as well as compulsive exercise and anabolic steroid use. Gay men have been shown to perceive intense pressures to achieve an idealized body from inside and outside the LGBT community as a result of social media, advertisements, and pornography that focuses on the male body. Experimental evidence has shown that situations that increase state levels of self-objectification have direct ramifications on gay men’s judgements of their bodies and their eating behavior. This presentation will include a discussion on the role that such issues of body image may have on self-esteem and eating behaviors and ways that they may be addressed in treatment. The distinction between femininity and masculinity is made at a young age. Young boys are often praised when they exhibit characteristics/behaviors that are consistent with our Western culture’s notion of masculinity (i.e. strength, assertiveness, and power). This preference for masculinity in males transcends adolescence and heterosexual culture and is particularly prevalent in the virtual platforms of MSM. During this presentation data will be provided supporting the privileging of masculinity over femininity in men who have sex with men (MSM) culture, especially as is seen within virtual platforms such as dating apps. There will also be some hypothesis/exploration of

potential explanations for the apparent emphasis on masculinity in MSM culture.

Nurse Practitioners, Physician Assistants, and Prescribing Psychologists: Current Legal State, Differences, and Views for Psychiatric Expansion

Chair: Daniel Young Bigman, M.D.

Presenters: David Clements, M.D., Daniel Young Bigman, M.D.

Discussant: Phoumy Bounkeua, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the similarities and differences among nurse practitioners, physician assistants, and prescribing psychologists.; 2) Recognize the current legal state and national guidelines for midlevel practitioner practice and prescribing psychologists.; 3) Provide knowledge to the debate towards the practice of prescribing psychologists.; and 4) Engage in a discussion to utilize non-physician health care practitioners in the field of Psychiatry.

SUMMARY:

There continues to be a national shortage of physicians nonetheless psychiatrists. Over the past few decades, nurse practitioners (NP) and physician assistants (PA) have provided improved health care access. In addition, there has been ongoing financial benefit to the utilization of non-physician practitioners by decreasing costs and financial burden. With much debate, prescribing psychologists have slowly been achieving state practice recognition. Our session will introduce participants to the scope of practice of NP's, PA's, and prescribing psychologists. We will provide a review of evidence-based literature of non-physician prescribers and its role in access of health care and expanding the field of psychiatry. In addition, we will describe the benefits and challenges faced with expanding NP's, PA's, and prescribing psychologists in the field of Psychiatry. During our session, we will provide participants with an opportunity for case discussion and provide a concluding open forum.

Opioids, Depression and Suicide: A Deadly Trio

Chairs: Steven Grant, Geetha Subramaniam, M.D.

Presenters: Maria Antonia Oquendo, M.D., Ph.D., Charles Barnet Nemeroff, M.D., Ph.D., Jon-Kar Zubieta, M.D., Ph.D., Jordan Karp, M.D., Richard Ries, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Have knowledge of overlap between accidental opioid overdose and intention opioid overdose/suicide; 2) Have knowledge of the common biological mechanisms between opioid abuse, depression, and suicide; and 3) Have knowledge of advances in treatments to prevent suicide prevention in depression and opioid abuse

SUMMARY:

Opioid-related fatalities are rising dramatically, and it is likely that many opioid-related deaths are suicides. This session will explore the interaction between two major risk factors for suicide, opioids and depression. Speakers will focus on biological and psychosocial factors that link these two risk factors with suicide and a novel treatment approach to prevention of addiction related suicides. The session will provide an extended period for questions and interactions with the audience.

Overstimulated: Sensory Processing Disorder in Adult Psychopathology

Chair: Elyse Huey, M.D.

Presenters: Nikhil Pillarisetti Rao, M.D., Shannon Bush

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define sensory processing disorder as a distinct clinical and research entity; 2) Discuss criteria and presentation of sensory processing disorder; 3) Explore research and clinical controversy regarding the diagnosis through a brief review of the research as well as comparing and contrasting to related diseases; 4) Recognize how sensory processing disorder can present in the non-autistic adult presenting for psychiatric treatment through a series of cases; and 5) Develop a working knowledge of available treatment modalities

SUMMARY:

Before we can think or act we must first sense and perceive. Between these cognitive domains, our brains engage in higher-level recognition, modulation, filtering, and association across multiple sensory modalities. Individuals with sensory processing/integration difficulties often struggle with too many inputs, avoid some modalities of sensory stimulation, or unconsciously pursue others. Interest in dysfunction of sensory processing continues to grow amongst pediatric mental health and developmental specialists, and parents of afflicted children. Sensory Processing Disorder (SPD) is now understood to be a phenomenon distinct from Autism Spectrum Disorder with implications for learning, attention, and anxiety pathology, as well as traumatic brain injury. However, despite the growth of targeted occupational therapy interventions, the Sensory processing disorder dysfunction and treatment remain polarizing, with several major professional bodies taking opposite stances with regard to legitimacy and relative import. Historically characterized as a facet of other neurodevelopmental concerns and only recently appreciated for its more pervasive nature, it remains probable that many adults with SPD have not been identified. Furthermore, SPD may contribute to patients' psychiatric chief concern, whether anxiety, agoraphobia, depression, psychosis, or even pain syndromes. This is problematic given that the pathophysiology of SPD may mimic or contribute to the severity of more classic psychiatric disorders without responding to the treatment for those disorders. This session will begin with a discussion of the history of Sensory Processing Disorder, including a review of the functional and physiologic evidence for and against it as a distinct clinical entity. Participants will be given handouts of sensory processing issues associated with schizophrenia, ADHD, and Autism. Speakers and participants will then discuss a series of three to five patients seen by the speakers in routine adult psychiatry practice whose psychiatric concerns heralded underlying sensory dysfunction. We will conclude with a discussion of treatment modalities including self-management, occupational therapy, and medications.

Overview of the Neurophysiology and Psychiatric Treatment of Stuttering

Chair: Gerald A. Maguire, M.D.

Presenters: Michele A. Nelson, M.D., Soo-Eun Chang, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the history of psychiatric treatment with respect to stuttering and fluency disorders; 2) Discuss the neural bases of stuttering and review the brain imaging findings and genetics of stuttering; 3) Review the DSM 5 diagnostic criteria for stuttering; and 4) Identify psychiatric treatments for stuttering, review their outcomes and address treatment of comorbid conditions

SUMMARY:

Stuttering is primarily a childhood onset disorder that affects the smooth flow of speech production. Persistent stuttering is a neurodevelopmental speech fluency disorder, characterized by the temporary interruption between the intention of speaking and the motor system response (Alm, 2015). This may take the form of involuntary speech blocks, sound and syllable repetitions, and sound prolongations. Stuttering therefore affects people of all ages and can compromise the quality of life of people who stutter (PWS). Affecting 5% of all preschool age children, most grow out of stuttering naturally within 2-3 years, whereas for an estimated 1% of the population, stuttering becomes a life-long chronic condition that can lead to major psychosocial consequences. Though etiology of stuttering remains unclear, in this symposium we explore recent findings from brain imaging and genetics studies that provide clues to possible pathomechanisms of the disorder. We will explore the DSM 5 diagnostic criteria and will review the differences between historical and current knowledge about the nature and potential causes of stuttering. In addition, we will review why the most common presentation of stuttering, that with onset in early childhood, is now considered to be a developmental communication disorder, with two additional codes added to accommodate patients whose symptoms arise after neurological or cardiovascular insult. We will review the growing evidence of psychiatric treatment in stuttering including pharmacologic and psychotherapeutic

approaches. We will also review how best to treat the common comorbid treatments seen with stuttering including Attention Deficit Hyperactivity Disorder, Social Anxiety Disorder and Obsessive Compulsive Disorder.

“Patient-Centered Lawyers” as an Innovation to Promote Health Equity: Making the Case for Medical-Legal Partnership in Behavioral Health Settings

Chairs: Ruth S. Shim, M.D., M.P.H., Mallory Curran
Presenters: Gregory Michael Singleton, M.D., Jack Tsai

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how medical-legal partnerships (MLPs) serve as an intervention to address the social determinants of mental health and promote health equity; 2) Create a concrete action plan to gain investment in MLP start-ups; and 3) Utilize evaluation and research methods to determine the effectiveness of legal interventions in achieving measurable outcomes for behavioral health patients and institutions

SUMMARY:

The social determinants of mental health are responsible for many of the mental health inequities and poor outcomes for people with mental illness. An increasing number of medical-legal partnerships (MLPs) are teaming patient-centered lawyers with behavioral health clinicians to address mental health-related social needs and promote recovery. This session will build upon a three-part online training series* on the social determinants of mental health and medical-legal partnership that all participants will be strongly encouraged to view prior to the Annual Meeting. This session will focus on two aspects of “making the case” for MLP: 1) convincing health care administrators to invest in MLP start-ups, and 2) sustaining MLPs through the deployment of evaluation and research methods needed to document outcomes and impact. In this session, a psychiatrist affiliated with a leading behavioral health MLP in Indiana will present case examples on how MLPs have benefited patients, transformed clinical practice, and provided a pathway to effect policy change, and how these

successes led his health organization to sustain the MLP through direct financial support. A psychologist-researcher will then present findings from an ongoing, IRB-approved study on MLP services provided to veterans with behavioral health needs and how those MLP services have been shown to improve housing, income, and mental health. The researcher will also address the opportunities and challenges inherent in quantifying MLP impact on patients. Participants will break into small groups at two points in the session: first, to brainstorm ways to secure investment in MLP from within the participants’ own healthcare institutions, and second, to brainstorm methodologies for developing process measures, tracking financial outcomes for patients and healthcare institutions, and documenting long-term mental health-related outcomes. *The proposal for the associated online training series is currently pending with the APA’s Division of Education. Please contact Deputy Director Nina Taylor, MA for updated information. Participants will also have the opportunity to attend a proposed companion session at the Annual Meeting, “Immigration Status as a Social Determinant of Mental Health: What Can Psychiatrists Do to Support Patients and Communities? A Call to Action.”

Pediatric Integrated Care: The Big Picture and Practical Nuts and Bolts

Chair: Sarah Yvonne Vinson, M.D.
Presenters: Lori E. Raney, M.D., Justine J. Larson, M.D., M.P.H., Seema Shah, M.D., Mary T. Gabriel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify key policies impacting pediatric primary care integration and Articulate the rationale for the psychiatrist’s role in shaping policy; 2) Describe potential funding sources including federal government resources for pediatric primary care integration; 3) Understand national trends in pediatric primary care implementation and funding; 4) Identify best practices in serving as an outpatient pediatric integrated care consultant; and 5) Identify approaches for assisting primary care clinic administrators with policies and procedures related to children’s mental health care

SUMMARY:

Of all of the pediatric sub-specialties, pediatricians have identified child and adolescent psychiatry as one of the most difficult to refer to in a timely manner. The problem is a predictable one – increasing demand for children’s mental health interventions in the setting of provider shortages across the country. The nuances and special considerations inherent in working with youth and families preclude a one-size-fits-all approach that simply transfers adult or general integrated care approaches to pediatric settings. The market is calling upon child and adolescent psychiatrists to apply their knowledge and skills in settings and in manners that they were not prepared for during residency or fellowship training. Furthermore, with new models of care comes the need for new funding structures. Understanding of the practicalities of billing and reimbursement are key to the sustainability of integrated care interventions. While clinicians working in integrated care have a keen appreciation for the demand and are needed to help expand access to services through this promising treatment model, policies matter. Indeed, the sustainability of integrated care in practice is often dependent on funding sources impacted by policy. Additionally, sound, clinically-informed policy can improve the efficiency of integrated care interventions. This work may require cross-disciplinary collaboration with state and federal government officials, governing bodies of major hospital systems, and leadership within primary care professional organizations. In this session, psychiatrists with unique perspectives and hands-on experience shaping policy will provide information and lead group discussions regarding policy implementation and advocacy as well as leveraging resources in furtherance of pediatric integrated care expansion. Additionally, psychiatrists with ground-floor experience working in integrated care will provide attendees with key resources, approaches, and perspectives in the nuts and bolts of pediatric integrated care.

Peripartum, Gynecologic, and Primary Care for Women With Serious Mental Illness: New Initiatives and Challenges

Chair: Alison Hwang, M.D., Ph.D.

Presenters: Monique Candace James, M.D., Alissa Peterson, M.D., Kelly Irwin, M.D., Christina V. Mangurian, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize key disparities in process, outcome, and structural measures in preventive, obstetric, and gynecologic care for women with serious mental illness compared to the general population; 2) Describe the evidence base for initiatives for peripartum and primary care for women with serious mental illness; 3) Discuss innovative models for delivering obstetric, gynecologic, and primary care to women with serious mental illness in inpatient hospital and community mental health center settings; and 4) Brainstorm pathways forward that promote inclusion and equity in health care delivery for women with serious mental illness

SUMMARY:

Although most psychiatrists are aware of cardiovascular disease risk among people with serious mental illness, few are aware of disparities in women’s health for this vulnerable group. Recent work by this panel’s presenters has found that women with serious mental illness experience disparities in obstetric/gynecologic and primary care, including contraception, peripartum management, and breast and cervical cancer screenings. In this session, speakers will present innovative models of integrating preventive and peripartum services into specialty mental health care for women with serious mental illness. The presenters are clinicians, researchers, and residency program faculty who have launched programs and initiatives in a variety of settings, from county hospitals to cancer centers to community mental health clinics. We will use case studies as a starting point to discuss the care gap for this population and its contribution to premature mortality for women with serious mental illness. Through small groups and facilitated discussion, audience participants will have time to share their experiences and ideas for novel approaches to delivering preventive and obstetric/gynecologic services to women with serious mental illness, in efforts to address disparities in care and life expectancy for this population.

Perspective Matters: Engaging in Inclusive Recovery in Serious Mental Illness

Chair: Mariken Beatrijs de Koning, M.D., Ph.D.

Presenters: Robin M. van Eck, M.D., Steven

Berendsen, M.D., Thijs J. Burger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Distinguish how staging and course can influence recovery in serious mental illness; 2) Distinguish the different perspectives on recovery (symptomatic, socially and personally) that service users, relatives and healthcare professionals may have in different stages; 3) Engage in a discussion on dilemmas that may arise from service users', relatives' and healthcare professional perspectives on recovery; and 4) Identify with multiple perspectives

SUMMARY:

Recovery has become an increasingly important aspect of care in mental health services all over the world. Recovery-oriented practices have especially emerged for schizophrenia, which has traditionally been seen as a condition with an unfavorable course. Since the second half of the 20th-century patient organizations have challenged the assumption that people with schizophrenia cannot live a productive and satisfying life. Patients have emphasized that recovery is a process that can occur even when psychotic symptoms are persistent. Scientific- and patient-based influences have resulted in a clinical and a personal definition of recovery in schizophrenia. The concept of personal recovery has gained influence in mental health care for all patients with severe mental illness (SMI). Self-governance and autonomy are important aspects of the personal recovery concept. However, traditionally, a primary treatment goal of patients with SMI has been clinical recovery, which includes at least remission of symptoms. Patients, relatives and healthcare professionals can be faced with conflicting views or internal conflicts when personal recovery and medical paradigms clash. We will discuss the concept of recovery in SMI in different patient groups and from multiple points of view. We will invite the audience to identify with these perspectives. We will start with a short introduction

on the background of the concepts illness, recovery and resilience from a historical and philosophical perspective. Hereafter we will present the conclusions of quantitative studies in three different patient groups with SMI: In 105 outpatients with SMI from outreaching outpatient teams, we found that only affective symptoms, and not psychotic symptoms, significantly predicted personal recovery. We discuss the implications of this finding (1, 2). In 258 inpatients on an acute psychiatric ward who met DSM-IV criteria for schizophrenia spectrum disorders, we found higher severity scores of multiple clinical profilers in more advanced stages of their disease. We discuss the implications for the contribution of crisis intervention to recovery on the long term (3). In 70 patients with SMI from clinics for long-term (> one year) clinical treatment, all with a high level of therapy-resistance, we retrospectively identified possible predictors of the unfavourable course of their disease. We will hypothesize about possibilities to intervene earlier to prevent stagnation of recovery processes. Finally, we will present preliminary results of our qualitative study "Recovery in Perspective" in which patients, relatives and healthcare professionals are interviewed by a researcher and an expert by experience. Three video fragments from these interviews will be shown and we will discuss the multiple perspectives with the audience. Statements and straw polling will be used to engage the audience in a discussion of dilemmas that may result from these perspectives in clinical practice.

Political Leadership and the Role of Psychiatry

Chair: Nassir Ghaemi, M.D.

Presenters: Charles Dike, MB.Ch.B., M.P.H., Stephen

N. Xenakis, M.D., Prudence T. Gourguechon, M.D.

Discussant: Alan A. Stone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To explore the role of psychiatry in understanding or influencing political leadership; 2) To examine the role of psychiatry in the 25th amendment on presidential disability; 3) To discuss the strengths and limitations of the Goldwater Rule; 4) To explore the role of manic-depressive illness in enhancing leadership traits; and 5) To analyze the concept of fitness for duty

SUMMARY:

The relationship between psychiatry and leadership, especially in the political setting, is a complex one. There is a large literature on the psychology of leadership, but the relevance of distinctly psychiatric concepts is less explored. One relevant aspect could be whether leaders might or might not have certain psychiatric diseases, diagnoses or traits, and how those psychiatric states might impact their leadership. Many assume that any psychopathology would be harmful for leadership, but there is some evidence that some conditions, like manic-depressive illness, might be helpful for leaders. If both benefits and harms can exist with psychiatric conditions for leaders, then the question arises how psychiatrists might be involved in assessing or impact leaders, especially political leaders. Two major ethical and legal features to this topic are the Goldwater Rule and the 25th amendment. In this symposium, those two aspects of the role of psychiatry for political leadership will be explored and discussed from differing viewpoints. The general question of how psychiatric conditions relate to leadership will be examined as well. The concept of fitness for duty from a psychological perspective will be analyzed. In general, the symposium will address the question of whether and to what extent there is a scientifically legitimate psychiatric contribution to evaluation of political and public leadership. Multiple perspectives will be provided and discussion and exploration of alternative viewpoints will be encouraged.

Promoting Inclusion: Innovative Strategies to Help Trainees Respond to Discriminatory or Excluding Comments From Faculty

Chair: Carmen E. Wiebe, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify various forms of exclusion or discrimination, including those that are unintentional or well-meaning; 2) Assist a resident in developing skills to cope with and respond to mistreatment from staff; and 3) Be more willing to advocate for inclusion and equality in participants' home institutions

SUMMARY:

Medical trainees from underrepresented groups often experience excluding attitudes in academic settings. Discriminatory comments may come from attendings, fellows, residents, medical students, other staff members and patients alike. They can range from less overt statements, like microaggressions, to more overt racism, sexism, homophobia, transphobia and so on. There is an abundance of literature describing the impact of this mistreatment on a resident's learning environment, as well as on their personal and professional wellbeing. However, there is minimal literature on advising residents on how to respond, particularly when the comments are made by their own attending staff, or another staff in a position of power. How can psychiatric educators help their residents both cope with, and communicate well in response to, mistreatment from attendings? This innovative workshop will introduce strategies borrowed from Dialectical Behaviour Therapy, a manualized, evidence-based psychotherapy which operationalizes its coping and communication techniques in a concrete, specific way. Removing the strategies from a psychotherapy context gives educators and trainees a framework to discuss coping and communicating without "doing therapy" or requiring formal training in the model. This workshop is geared both toward residents themselves, as well as toward attending staff who want to actively support minority residents and promote inclusion in their home institutions. Facilitators will interweave demonstration role-play, large group discussion and various brainstorming and skills practice exercises, to present strategies residents can use to both cope with and respond to excluding attitudes. Given that advocacy is generally agreed to be the most effective method to bring about system change, the workshop will have a special focus on helping a trainee structure a clear and non-defensive conversation with their training director as well.

Psychiatric Services Gold Star Symposium: My Smartphone Can Do What?! Mobile Health and the Future of Care for People With Serious Mental Illness

Chair: Dror Ben-Zeev, Ph.D.

Presenters: Lisa Dixon, M.D., Jurgen Unutzer, M.D., M.A., M.P.H.

Discussants: Eileen Cody, Brandon Chuang

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the penetration and use of mobile technologies among people with SMI; 2) Understand the ways in which patients are willing and able to use mHealth; 3) Identify specific mHealth interventions that show promise for treatment of SMI; and 4) Recognize next steps needed to fully integrate mHealth approaches into practice

SUMMARY:

We are witnessing technological breakthroughs that create exciting opportunities to improve the outcomes of people with serious mental illnesses (SMI). Digital technologies are now within the reach of the vast majority of the world's population, including people with SMI. Technological resources can help enhance mental health services by creating new pipelines for dissemination of evidence-based practices and by expanding the reach of potent care. On its own, this would have tremendous value for individuals with mental health problems, clinicians, and healthcare systems. However, new digital software and hardware may enable us to redefine the very nature of mental healthcare by building on research, intervention, and prevention approaches that emerge from novel paradigms and clinical frameworks that focus on continuous and seamless data collection, delivery of services in the environments in which people actually negotiate their lives, and interventions that are administered in dosages, frequencies, and formats that fit the capacities and characteristics of individual patients. In 2018, Psychiatric Services (APA Journal) published the first report of a randomized comparative effectiveness trial examining a smartphone intervention vs clinic-based group intervention for people with SMI: <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201800063>. The paper became one of the most downloaded, tweeted, and media-covered Psychiatric Services articles in 2018. This paper will serve as the starting point for a diverse stakeholder discussion about mHealth and the future of mental health care. The lead author and Director of the

University of Washington's mHealth for Mental Health Program (Dr. Dror Ben-Zeev) will kick things off by presenting the study findings and providing a brief overview of the latest breakthroughs and discoveries in the field of mobile Health for SMI, including treatment apps, clinical texting approaches, and multi-modal remote sensing. Dr. Ben-Zeev will then lead a panel discussion and Q&A with the Editor-in-Chief of Psychiatric Services (Dr. Lisa Dixon), a clinical/healthcare system leader (Dr. Jurgen Unutzer, Chair of Psychiatry at the University of Washington), a stakeholder with lived experience of SMI and use digital health resources (Mr. Brandon Chuang) and Policy/ Legislative leader (Representative Eileen Cody, chair of the House Health Care & Wellness Committee, Washington State House of Representatives). The panelists will discuss how mHealth fits within the broader field of psychiatry, what is exciting to patients and family members, what are the organizational barriers and opportunities ahead, and what legislative action is needed to move mHealth from research to broad real-world practice. The session will include videos and demonstration of treatment apps, and conclude with moderated Q&A with audience members.

Psychiatrists and Law Enforcement Agencies: When Do We Really Have to Tell on Our Patients?

Chair: Lama Bazzi, M.D.

Presenters: Yassir Osama Mahgoub, M.D., Camila Albuquerque De Brito Gomes, M.D.

Discussants: Steven Kenny Hoge, M.D., Elie Aoun, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify challenges faced by treating psychiatrists when detectives, secret service agents, fire marshals, and other law enforcement agencies inquire about psychiatric patients; 2) Discuss the duty psychiatrists owe to maintaining patient confidentiality while ensuring adequate cooperation with law enforcement agencies; 3) Understand when and to what extent psychiatrists are obligated to report possible crimes committed by patients to law enforcement and testify against patients in court; and 4) Appreciate the importance of communication and collaboration with hospital

legal representation and administration when patients have legal issues

SUMMARY:

Psychiatrists face the implications that social determinants of health have on our patients' diagnoses and prognoses on a daily basis. Involvement with the justice system is one such factor. Society imposes upon psychiatrists legal responsibilities aimed at promoting public health and maintaining the safety of communities. These include mandated reporting of suspected child and elder abuse, and discharging Tarasoff duties. Under some circumstances, the legal responsibilities may conflict with ethical obligations to the patient, including maintaining confidentiality. Promoting public health as well as safety can mean we must limit a patient's freedom of movement or treat a patient over his or her objection. However, many psychiatrists have questions about the proper scope and the limits of their role in assisting law enforcement in their activities. Psychiatrists working in various hospital settings interact with law enforcement agents on a daily basis. Hospital security is sometimes armed or is in communication with local police in order to maintain the safety of staff and patients. Security personnel are often called upon to assist with disarming, restraining, and de-escalating patients threatening to harm themselves, staff members, or other patients. There is a paucity of literature specifically addressing Psychiatrists' handling of law enforcement requests for information, and many clinicians may respond differently when faced with the same scenario. This often depends on the circumstances of law enforcement involvement, the law enforcement agents' demeanor, and the presence or absence of a search/arrest warrant. The decision to allow law enforcement access to the patient is usually made by the clinician on the spot, and could leave him/her vulnerable to serious unintended consequences. We will present participants with four uniquely challenging cases where we had to interact with different law enforcement agencies. The first case involved inquiries by the Secret Service into a patient allegedly threatening the President. The second involved Fire Marshals presenting with a warrant to arrest a patient for a crime he allegedly committed while in the midst of a manic episode. The third

involved hospital administration calling police to report a psychiatric inpatient allegedly assaulting another patient. A doctor testified before a Grand Jury, and the patient was indicted. The fourth involved a staff member calling police to press charges against an assaultive patient. In this interactive workshop, we will use story boarding to illustrate each case, step by step. We will use audience polling to allow participants to choose what they would have done in each unique scenario and reveal what the treatment teams did. The experts on the panel will weigh in on what should be done ideally in similar situations. Goals include increasing participants' comfort in interacting with law enforcement in different capacities and to inform future practices.

Psychiatry in the City of Quartz: Notes on the Clinical Ethnography of Severe Mental Illness and Social Inequality

Chair: Gregory Gabrellas, M.D., M.A.

Presenters: Enrico Guanzon Castillo, M.D., Ippolytos

Andreas Kalofonos, M.D., Ph.D., M.P.H., Joel

Braslow, M.D., Ph.D.

Discussant: Helena B. Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe clinical ethnography as a method of investigation; 2) Understand the basic social and historical context of community mental health in Los Angeles; and 3) Apply ideas from the social sciences to issues facing public psychiatry

SUMMARY:

Those with severe mental illness face health and social inequities, including early mortality, limited access to health care, and disproportionately high rates of homelessness, incarceration, and poverty. Clinicians are trained to recognize and address individual-level psychosocial factors, such as insecure housing, legal trouble, and co-morbid substance or trauma that reinforce these inequities and present clear barriers to effective mental health care. Yet the upstream social and structural factors, at the level of social institutions and policies, work insidiously and influence downstream clinical decision-making and opportunities for well-being.

This workshop will show how large upstream policies and structures influence individual moments in the clinic, in jails, and on the streets, indicating opportunities where psychiatrists can intervene to address these complex issues. In particular, this session will highlight the work of clinicians and social researchers carrying out clinical and ethnographic study of the social conditions of severe mental illness in Los Angeles, California (where Mike Davis has dubbed the "city of quartz"). Three presentations will apply approaches from the social sciences to instances in everyday clinical practice in which clinical logic breaks down in the delivery of public mental health services, from policy to direct clinical care. They will show how social history and ethnography can help appreciate the obstacles faced by community psychiatrists in Los Angeles, particularly in terms of homelessness, incarceration, and addiction. Dr. Gabrellas, from UCLA, will provide a brief review of the social history of LA and its Department of Mental Health (DMH). Drs. Braslow, Castillo, and Kalofonos from UCLA, DMH, and the VA Greater Los Angeles Health Care System, respectively, will present on their ongoing clinical-ethnographic research. Dr. Hansen from NYU will offer critical responses, and reflect on the relationships among the issues facing LA and New York City. Each presenter will then lead a small group discussion with members of the audience to clarify the group's general approach and preliminary findings, and encourage participants to apply what is discussed to settings where they practice.

Psychodynamic Psychotherapy of Obsessive-Compulsive Personality Disorder

Chair: Glen Owens Gabbard, M.D.

Presenter: Holly D. Crisp, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of typical defense mechanisms in OCPD.; 2) Demonstrate knowledge of common transferences and countertransferences in OCPD.; and 3) Demonstrate knowledge of interpretive and non-interpretive interventions that are effective in OCPD.

SUMMARY:

Obsessive-compulsive personality disorder is the most common personality disorder in the United States according to some studies. Yet there is a paucity of data on the challenge of treating the condition. Among the issues that therapists must address are the following: perfectionism, rigidity and stubbornness, intellectualizing defenses against emotions, fear of losing control as well as an attempt to control the therapist, competitiveness with the therapist, reluctance to accept the need for change, and a feeling of moral superiority. These are problems that are experienced in their daily lives and re-appear in the psychotherapeutic setting. There are limited data from controlled studies, but those that exist suggest that psychodynamic therapy can be effective in treating these patients. These studies confirm what clinicians know, namely, that long-term treatment is necessary. Hence one of the countertransference issues that frequently arises is impatience in the clinician because of a variety of resistances to change encountered in the patient, which involve the following defense mechanisms: intellectualization, isolation of affect, and displacement. These countertransference feelings include boredom, frustration with obsessional overinclusiveness, and a feeling of being distanced by the patient. Transferences to the therapist may include an effort to be the perfect patient to receive admiration from the therapist, a tendency to compete with the therapist, and a wish to control what the therapist says and does. In this Case Conference, two experts on obsessive-compulsive personality disorder will each present a case involving a patient with OCPD. Each will discuss the other's case and invite audience participation.

Psychopharmacology and Ethnicity

Chair: Stephen Michael Stahl, M.D., Ph.D.

Presenters: Donatella Marazziti, Antonio Ventriglio, Dinesh Bhugra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the great variability in the response to psychotropic compounds; 2) Recognize that ethnicity should be included amongst the most crucial factors influencing psychopharmacology; 3) Highlight how genetic and non-genetic variations of different parameters and

structures, such as the cytochromes, may influence the metabolism of psychotropic drugs; and 4) Recognize that tailored pharmacotherapeutic care for patients who are of diverse ethnic and cultural backgrounds and will represent a significant contribution to the entire field of psychopharmacology

SUMMARY:

Evidence shows with that there is a great variability in the response to psychotropic compounds, as a consequence of the interplay between individuals' factors, such as sex, age, genetics, or variables related to their life habits, e.g., smoking, alcohol or drug use, diet and others. With no doubt ethnicity should be included amongst the most crucial factors influencing psychopharmacology, Different data are already available underlying how the clinical pictures of some common psychiatric disorders may vary according to ethnicity. Similarly, since some decades ago, it was described how the pharmacokinetics and side effect profile of different psychotropic compounds may show a race-related patterns. Not surprisingly, data are accumulating highlighting genetic and non-genetic variations of a series of parameters and structures, such as the cytochromes influencing the metabolism of psychotropic drugs and, as such, their pharmacokinetics and pharmacodynamics. Literature suggests that the compounds possibly showing difference between ethnic groups should be those undergoing active gut and/or hepatic first pass metabolism, or are tightly bound to plasma proteins, especially alpha1-acid glycoprotein. Indeed, Asians seems to require lower doses of antidepressants, antipsychotics and benzodiazepines than Caucasians, and Africans of antipsychotics. Besides that, variations of the genes encoding therapeutic targets of psychotropics (e.g., neurotransmitter transporters and receptors) have been also described. It is urgent that several studies should be carried out to understand how neurobiological and genetic processes, and cultural/dietary habits, as well as their interactions, may impact psychopharmacological responses. Such knowledge will be crucial for the individually tailored pharmacotherapeutic care of the majority of patients who are of diverse ethnic and cultural backgrounds and will represent a significant

contribution to the entire field of psychopharmacology

PTSD at Our Nation's Trauma Centers: A Problem That Can No Longer Be Ignored

Chair: James Colin Rachal, M.D.

Presenters: Stephen A. Wyatt, D.O., William Ford Wright, M.D., Ashley Christmas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Identify risk factors for the development of PTSD in patients who sustain traumatic injuries most commonly seen at our nation's trauma centers.; 2) 2. Explore the role of substance abuse and addiction as an underlying predisposing factor for the development of PTSD following traumatic injuries.; and 3) 3. Discuss the ramifications associated with substance abuse, PTSD and traumatic injuries in relation to the current opioid crisis

SUMMARY:

Currently few available resources exist to screen potentially at-risk patients for PTSD at our nation's trauma centers prior to discharge. Factors associated with development of PTSD include poor social support, low income, uninsured, intentional injury, and drug use prior to injury. Not surprisingly, the identification of PTSD in this patient population has been associated with increased length of stay, higher suicide rate, increased risk of re-admission, and delays in return to work (Zatzick, 2007). While the American College of Surgeons now suggests that trauma centers provide PTSD screening, and will certainly mandate this in the future, these centers must proactively begin to plan not only for adequate screening process, but also for potential prevention and treatment opportunities in a public health model. In this interactive workshop, the presenters will first introduce several challenges facing our nation's trauma centers and provide insight into a potentially successful screening model. A trauma surgeon will discuss the findings of a pilot study of 494 trauma patients over a 2 month period conducted at one of our nation's busiest trauma centers. Furthermore, presenters will discuss the potential importance of addiction psychiatry in future outreach and prevention initiatives given that

drug abuse history and prior psychiatric diagnoses were found to be independent risk factors for the development of PTSD. We will also discuss the current opioid epidemic in relation to these findings, and how earlier identification and treatment will play a role in reducing the impact. We will focus on a current initiative at Atrium Health that allows for a rapid screen of the electronic medical record to provide a prescriber with specific risk data in real time before the prescription of a controlled substance and the growing need for public health efforts to address these problems in a multidisciplinary approach. Following presentations, we will conduct a panel/large group session to facilitate interactive discussions regarding the opportunities and stakeholders for screening and treatment initiatives for those trauma patients identified to be at high risk for the development of PTSD.

Racism and Psychiatry: Understanding Context and Developing Policies for Undoing Structural Racism

Chair: Derri Lynn Shtasel, M.D., M.P.H.

Presenters: David Louis Beckmann, M.D., M.P.H., Margarita Alegria, Ph.D., Virginia A. Brown, Ph.D., M.A., Helena B. Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define structural racism.; 2) Name three systemic causes of racial inequities in behavioral health care.; and 3) Describe three policy interventions that would disrupt modern-day systems of oppression and improve the health status of racial minorities.

SUMMARY:

This workshop is informed by the content of the recent volume, *Racism and Psychiatry: Contemporary Issues and Interventions* (Medlock et al, eds., 2018). Authors will be joined by expert presenters who will introduce a framework for understanding racism as structural and pervasive within society, influencing systems and access to healthcare, housing, education, workforce, and criminal justice. Using the public mental health system and the criminal justice system as examples, presenters will unpack the origin of racism in these arenas, describe their intersection with behavioral

health care, and then challenge attendees to also think about solutions (i.e., strategies for dismantling systems of oppression). Contemporary policy interventions, particularly those addressing law enforcement and differential access to behavioral health care, will be discussed.

Reason for Hope or Despair: Effective Help for Families of Those With Borderline Personality Disorder

Chair: Brian A. Palmer, M.D., M.P.H.

Presenters: Perry Hoffman, Ph.D., Liza Preminger, Joy Rynearson

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Articulate patterns of reactions in families of people with BPD and how to tailor guidance appropriately.; 2) Understand the severity of stress and symptom burden experienced by family members living with someone with BPD; 3) Recognize the ways that stabilizing a family system can effectively reduce BPD patients' symptoms.; 4) Demonstrate how to make an appropriate referral to additional support and training for family members interested in learning skills to manage more effectively.; and 5) Understand how effective skills and support can decrease psychiatric symptoms in families impacted by BPD.

SUMMARY:

People with Borderline Personality Disorder demonstrate their most severe symptoms in relationships with those closest to them. While this is widely appreciated by physicians and other mental health providers who work with patients with BPD, little professional attention is given to the terror, burden, grief, rage, and fear frequently experienced by family members. This interactive workshop will build on the subjective experience of audience members and videotaped interviews with family members to outline patterns of ways in which family members (like professionals) may respond to borderline relatives. Patterns of response are frequently either overly controlling or overly avoidant, and families often experience helplessness as they try to do more or do less with little discernable benefit. Based on this understanding, the workshop will outline ways to recognize a guide

family members to a stance that is at once more accepting of the reality of the difficult situation (and thus helpful to the family member) and paradoxically more helpful to the BPD patient. Family members themselves will lead part of the workshop, describing their experience as leaders of the Family Connections program, a 12-week, free, evidence-based, manualized, education and skills training and support program now available in 22 countries and typically led by family members. It provides current information and research on BPD and family functioning, individual coping and family skills training; and the opportunity to develop a support network based on common experience with the other group members. Research data will be shared, including statistically significant decreases in grief, burden, and depression measures – with a corresponding increase in mastery/empowerment. In addition, specific new findings about the experience of siblings will be presented, including experiences of resentment or helplessness and the impact on well-siblings' self-concept. The workshop will end with a discussion of how clinicians can, within the busy realities of current practice, most effectively guide family members impacted by borderline personality disorder. Ample time for audience discussion and experiences will help make for a meaningful exchange and enhance understanding of this important and difficult clinical dilemma.

Rebels With a Cause: Nurturing the Provider for Successful Program Evolution

Chair: Shilpa R. Taufique, Ph.D.

Presenter: Brandon Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review basic premises of the “group-as-a-whole” theoretical framework; 2) Identify how this framework can be applied to better understand several aspects of teamwork; 3) Understand ways in which clinical program development may occur in a non-linear fashion; 4) Understand the importance of prioritizing provider well-being for overall improvements in patient care; and 5) Identify examples of how to improve provider well-being in one's own settings

SUMMARY:

“The world is so complex, no one person has the skills or knowledge to accomplish all that we want to accomplish. Interdisciplinary teams are the way to make that happen.” (Susan McDaniel, PhD, 2016 American Psychological Association President) The days of business as usual in health care are long gone. We often hear recommendations for “team work” in order to address rising costs and inconsistent quality of health care. Sometimes teams seem to work seamlessly with little effort. Other times, poorly combined individuals derail even the most well-intentioned and hardworking clinicians. While efforts to create effective teams have involved consideration of surface-level attributes of individual team members, recent research is uncovering that a team's success is largely based on “deep-level” factors that can't be seen at a glance. Using the theoretical framework of “group-as-a-whole,” the presenters will discuss how CARES, a clinical outpatient program for high risk adolescents and young adults evolved from a small, grant-funded, simple program into a comprehensive, collaborative, and integrated mental health, substance abuse, and educational clinical service. From this framework, teams are conceptualized as living systems, and team members are interdependent co-actors who are bonded together in an “unconscious tacit agreement,” working toward common goals. Presenters will discuss how obstacles to team-building were addressed using the “group-as-a-whole” framework to work through various dynamics among staff members, and allowing for the effective evolution of a productive team. Particular emphasis will be placed on the importance of nurturing the provider in order to build a strong, flexible, and organic team that can evolve with changing clinical, fiscal, and societal demands. Presenters will then engage with participants in discussion about how to operationalize use of this framework in their own clinical settings, and facilitate small-group brainstorming sessions to identify ways to incorporate approaches to provider well-being that may improve their overall patient care.

Relevant, Efficient, and Fun (REF) Videos for Quality Improvement and Patient Safety Learning for Psychiatrists and Psychiatric Residents

Chair: Jacqueline A. Hobbs, M.D.

Presenters: Amanda Mihalik-Wenger, M.D., Britany Griffin

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review medical errors and other patient safety events that occur in psychiatry; 2) Identify learning needs pertaining to psychiatry quality improvement and patient safety; 3) Assess knowledge of quality improvement and patient safety concepts in psychiatry; and 4) Evaluate new quality improvement and patient safety in psychiatry video trainings

SUMMARY:

It is estimated that in the United States hundreds of thousands of patients die and millions suffer harm annually from medical errors. Psychiatric practice, in comparison to other fields of medicine, has both common and unique types of medical errors and patient safety events that contribute to patient harm statistics. Examples include suicide attempts, assaults, medication errors, elopements, falls, and contraband-related events. We have surveyed board-certified psychiatrists (N=67) nationally from a variety of practice settings and determined some major areas of need for education in quality improvement and patient safety relevant to psychiatric practice. Quantitative and qualitative methods demonstrated that major areas of emphasis were medication safety/errors and suicide and violence risk/prevention. In response, we have developed a series of short training videos that are relevant, efficient, and fun (REF). Anonymous interactive audience polling using mobile devices will be performed to ascertain the learning needs of the session participants for comparison to the national survey. Three REF videos will be viewed as a large group. A pre- and post-test will be given to all participants to assist with self-assessment and retention of content. Ample time for discussion will be provided. In addition, a link to an e-book with psychiatric practice safety tips will be provided to participants and further discussed to assist their continued learning and teaching.

Research With Terrorists: Ethical Considerations

Chair: Allen R. Dyer, M.D., Ph.D.

Presenters: Philip Candilis, M.D., Najat Khaifa

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the ethical challenges in doing research with persons whose autonomy is constrained; 2) Appreciate ethical challenges in working in different cultures; and 3) Be familiar with ethical principles by which dilemmas or conflicts might be resolved.

SUMMARY:

Global terrorism presents one of the greatest threats to international peace and stability, yet there is little evidence to answer some of the most perplexing political and psychological questions about terrorism, terrorists, and terroristic behavior. Casting these questions in an ethical framework may help address questions about how research is conducted, designed, and interpreted, and how the ethics of research with human subjects is applied. Always problematic with populations whose autonomy is limited, such as prisoners, such research is even more difficult when the research is done cross-nationally, where cultural norms may be different from those of the researchers. This session reflects on a comparison study we have conducted with Iraqi inmates, convicted under the Iraqi anti-terrorism law, and compared with inmates convicted of non-terrorist murders, and normal controls. We observe the cross-cultural standards that differ from our own and raise a question about standard diagnostic nomenclature for anti-social personal disorder that may fail to account for changeable behaviors that may be better understood as pro-social and identity-affirming.

Revitalize Sleep Prescriptions: Sleep as Adjunctive Mood and Anxiety Treatment

Chair: Josephine Pardenilla Horita, D.O.

Presenters: Judy Kovell, M.D., Michelle Samson Maust, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the Neuropsychiatric interplay between sleep and Mood/Anxiety.; 2) Review evidence for sleep as treatment for Mood/Anxiety. ; 3) Review evidence for Motivation

Interviewing as a tool to change behavior.; 4) Formalize motivational interviewing skills to effectively prescribe healthier sleep habits and improve treatment outcomes. ; and 5) Provide resources to include MI skills, free mobile apps and online resources you can use today to optimize sleep.

SUMMARY:

It is all over the lay press: Better sleep equals a healthier, happier, thinner, more productive and potentially richer you! So why do our patients fail to prioritize sleep? Is it Big Pharma's unceasing sales pitch of "just ask your doctor"? Or as Simon Senek would say, are we too focused on the what and the how of sleep but not as skilled in communicating the "why" to sleep. To really help our patients find their true power, we have to sell them on investing effort to relearn how to self-soothe and sleep. As psychiatrists, we know sleep problems correlate with greater depression and exacerbate anxiety severity. We devote valuable time in taking a sleep history and teaching sleep hygiene. But all too often, we find ourselves feeling as frustrated as our patients, leading us to prescribe medications that don't fix and can potentially exacerbate sleep struggles. This workshop will revitalize psychiatrists' enthusiasm and ability to foster change in patients' sleep habits. By reviewing Motivational Interviewing (MI) tenants, modeling MI skills specifically targeted for sleep, and engaging the audience through audience participation tools, attendees will learn the skills to effect lasting improvement for patients with sleep, mood, and anxiety disorders. Participants will walk away with innovative ways to improve patients' sleep, as well as a review of the numerous resources available through online applications

Science of Wisdom

Chairs: Dilip V. Jeste, M.D., Dan German Blazer, M.D.

Presenters: Ellen Eun-Ok Lee, M.D., Bruce Miller

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will be able to describe the scientific construct of wisdom, including its specific components.; 2) At the conclusion of this session, participants will be able to use a new scale to

measure wisdom in their clinical practice.; 3) At the conclusion of this session, participants will be able to identify the brain regions and associated functions that are critical for wisdom.; 4) At the conclusion of this session, participants will be able to discuss the sociodemographic, psychosocial, and clinical associations of wisdom in persons with schizophrenia.; and 5) At the conclusion of this session, participants will be able to use specific interventions to enhance components of wisdom.

SUMMARY:

Wisdom has been discussed for centuries in religious and philosophical texts. However, in recent decades there has been growing empirical research on wisdom as a scientific construct. Studies have found that wisdom is linked to better overall health, well-being, happiness, life satisfaction, and resilience. Wisdom likely increases with aging, facilitating a possible evolutionary role of wise grandparents in transmitting wisdom to younger generations, promoting fitness of the species. Despite the loss of their own fertility and physical health, older adults help enhance their children's well-being, health, longevity, and fertility – the "Grandma Hypothesis" of wisdom. This Symposium will provide an overview of evidence-based science of wisdom and discuss a putative model of wisdom development that incorporates genetic, environmental, and evolutionary aspects of this construct. It will also include a discussion of wisdom in persons with schizophrenia. Dilip Jeste will summarize his research on definition and measurement of wisdom. Wisdom is a complex human trait with several specific components, including social decision making, emotional regulation, prosocial behaviors such as empathy and compassion, self-reflection, acceptance of uncertainty, decisiveness, and spirituality. Jeste's group recently developed a new San Diego Wisdom Scale to measure wisdom based on these components. Bruce Miller, a neurologist who is the Director of Global Brain Health Institute and a world expert on frontotemporal dementia, will describe how the different components of wisdom appear to be localized primarily in the prefrontal cortex and the limbic striatum. Frontotemporal dementia represents an antithesis of wisdom. Ellen Lee will present data on the relationship of wisdom to mental illnesses, especially schizophrenia, and

narrate a review of the clinical trials to enhance specific components of wisdom including emotional regulation, empathy, compassion, and spirituality. Finally, Dan Blazer, who has written on practical wisdom, will tie the different presentations together. He will discuss implications of wisdom at both individual and societal levels, and its contribution to human thriving. There is a need for a greater emphasis on promoting wisdom through our educational systems from elementary to professional (including medical) schools. The proposed session is fully consistent with the theme for the 2019 APA meeting – i.e., “Revitalize Psychiatry: Disrupt, Include, Engage, and Innovate” As the study of wisdom is an evolving area of research and wisdom-related policies and interventions may have great potential to improve outcomes for patients, providers and societies. The participants include three members of the National Academy of Medicine along with an APA Resident-Fellow member (Ellen Lee). There will be ample time for discussion involving the audience throughout the session.

Sexual Harassment: A Civil Interaction Between Law and Psychiatry

Chair: Ryan Colt Wagoner, M.D.

Presenters: Gregory Iannuzzi, M.D., Jennifer Yehl, M.D., Renee M. Sorrentino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the definition of sexual harassment and the legal history leading to this definition; 2) Demonstrate how sexual harassment can lead to psychiatric symptoms and how these are treated in this context; 3) Provide learners with the tools to approach an independent psychiatric examination of someone alleging sexual harassment; and 4) Educate learners on how to differentiate genuine trauma from delusions

SUMMARY:

Sexual harassment is not new a social issue, but has recently received more attention from high profile examples in Hollywood and Washington. With the growing media coverage and social movements seeking to bring these claims to light, the potential for civil litigation related to sexual harassment is on

the rise. The goal of this presentation will be to discuss how sexual harassment cases can often involve a psychiatrist, both in a treatment setting and in the role of an expert. Dr. Iannuzzi will define sexual harassment and review the legal history of cases involving this topic, with particular focus on civil litigation. He will also review why a forensic psychiatrist may be asked to provide an expert opinion in these cases. Dr. Yehl will detail possible psychiatric outcomes for victims of sexual harassment and how to consider these in a forensic evaluation. She will use examples of recent high profile celebrity statements to showcase how these outcomes can play out in the media. Dr. Wagoner will educate the audience on how to balance the skepticism common in a forensic evaluation against concerns for “victim blaming.” In particular, Dr. Wagoner will address the pitfalls present in evaluating sexual harassment cases where the victim could be delusional. Dr. Sorrentino will review possible defenses that could be raised in a sexual harassment claim, including sexual addiction.

Some Observations on Fifteen Years of Pharmacogenetic Research on Antidepressants

Presenters: Greer M. Murphy Jr., M.D., Ph.D., Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the difference between pharmacodynamic and pharmacogenetic predictors of response; 2) Understand that intolerance can be erroneously inferred to reflect inability to respond; 3) Understand that antidepressants are extruded from brain by an active pump that is encoded and regulated by the ABCB-1 gene; and 4) Understand the controversies regarding currently available genetic testing in depression treatment

SUMMARY:

Over the past 15 years considerable progress has been made in pharmacogenetic prediction of response in major depression, but there remains considerable controversy regarding the applicability of these measures to current practice. This combined presentation that is in honor of our collaborative research and our selection for the 2019

Mrazek Award will review our research in the pharmacogenetic prediction of antidepressant response and smoking cessation. We will also discuss current pharmacogenetic clinical uses and controversies. Our group has conducted a number of controlled trials in major depression where we have employed random assignment and double blind conditions. Initially, we utilized prospective collection of DNA in a randomized double-blind clinical trial that compared paroxetine to mirtazapine in geriatric depression. We will discuss work on antidepressant pharmacokinetics with an emphasis on CYP2D6 and CYP2C19 where we did not see significant genetic prediction of response or side effects. In contrast, we reported that variants of the serotonin 2A receptor gene and the serotonin transporter gene predicted intolerance to the SSRI paroxetine but not to mirtazapine. In our hands, intolerance to SSRI's and SNRI's are largely due to pharmacodynamic rather than pharmacokinetic genetic effects. Transport of multiple antidepressants out of brain is mediated by the P-glycoprotein pump encoded by the ABCB-1 gene. We have reported in multiple studies that variant in this gene predict response and side effects for a number of antidepressants (including paroxetine, escitalopram, venlafaxine, and sertraline) that are substrates for the pump but not for those that are not, e.g., mirtazapine. The clinical implications of each of these findings will be discussed. Pharmacogenetics can also be used to predict response to antidepressants in other indications. We explored prediction of response to bupropion and selegiline in smoking cessation in both adolescents and adults. Here, our studies and those of others have emphasized variants for cholinergic genes. Last, we will review the controversies regarding recent commercial efforts to develop algorithms for assessing genetic variation to predict antidepressant response in routine clinical practice.

Spiritually Integrated Cognitive Behavior Therapy

Chair: Matcheri S. Keshavan, M.D.

Presenters: Shadi Beshai, David H. Rosmarin, Ph.D., Michelle Pearce

Discussant: Cassandra Vieten, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the psychological importance of spirituality and religion within the clinical context; 2) Understand the practical relevance of spiritual and religious functioning in relation to psychotherapeutic (e.g., CBT) goals, language and concepts; 3) Identify ways to harness spiritual beliefs and practices within the framework of cognitive behavioral therapy; 4) Appreciate the specific contributions of different faith traditions to spiritually integrated psychotherapy for patients from diverse backgrounds; and 5) Know better how to address harmful spiritual beliefs and practices

SUMMARY:

Despite historical tensions between psychiatry and religion, growing attention is being paid to the relationship between spirituality/religion (S/R) and mental health. S/R, which remain highly prevalent in the U.S., can affect emotional functioning in both positive and negative ways. Many patients want to address spiritual issues in their mental health care, and a growing literature now describes best practices and outcomes of spiritually integrated psychotherapy, primarily within the framework of CBT. This session focuses on enhancing the competencies involved in culturally competent, spiritually sensitive care. They include, in addition to taking a spiritual history and respecting patient's spiritual beliefs and practices: recognizing psychologically relevant aspects of spirituality and religion within the clinical context; conceptualizing spiritual and religious functioning using psychotherapeutic (CBT) language and concepts; knowing how to initiate a discussion with patients about spirituality and religion; conducting a functional assessment of patients' spirituality and religion; using psychotherapeutic (CBT) methods to engage spiritual and religious concepts in order to enhance motivation, behavioral activation, and cognitive restructuring; and addressing clinically maladaptive spirituality and religion in a culturally sensitive manner. Presenters in this symposium will describe their use of spiritually integrated CBT within four major spiritual traditions: Dr. Keshavan, a professor of psychiatry at Harvard Medical School will discuss the relevance of Eastern (Hindu/Buddhist) insights for psychotherapy. Dr. Shadi Beshai, a psychologist at The University of

Regina will discuss CBT with Muslim patients. Dr. David Rosmarin, a psychologist at McLean Hospital and Harvard Medical School will discuss spiritually integrated therapy within a Jewish context. And Dr. Michelle Pearce, a psychologist at the University of Maryland who has authored "Cognitive Behavioral Therapy for Christians with Depression: A Tool-Based Primer" will describe her work in this area. Finally, Dr. Casandra Vietan, a psychologist and scientist at California Pacific Medical Center will serve as a discussant, providing an overview of research in this area.

Successfully Addressing Weight Gain in Patients With Serious Mental Illness

Chair: Amy N. Cohen, Ph.D.

Presenters: Teri S. Brister, Ph.D., John Torous, M.D., Donna Rolin, Ph.D., A.P.R.N., Alexander S. Young, M.D., M.H.S., Tristan Gorrindo, M.D., Patrick R. Hendry, Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify three ways that mental health professionals can intervene to help reduce obesity in those with serious mental illness; 2) Recognize three barriers to weight loss in those with serious mental illness; and 3) Understand how technology can be used to address weight issues in those with serious mental illness

SUMMARY:

Individuals with serious mental illness often have multiple comorbid medical problems, including high rates of obesity and diabetes, which can be effectively managed with activity and diet. In this population, weight loss services have efficacy in clinical trials. However, the impact of these services is muted in usual care clinics due to barriers at the patient- (e.g., poor motivation; transportation difficulties), provider- (e.g., limited time in the clinical encounter), and clinic-level (e.g., no space for groups; limited manpower). Typically, only a small proportion of patients receive appropriate services. Tailored services and innovative delivery methods are needed to reduce the early mortality rate seen in this population due in part to the deleterious effects of obesity. This symposium presents a range of approaches for successful delivery, uptake, and

impact of services targeting health behaviors in patients with serious mental illness. Medication adjustments and adjunctive medications to address weight gain will be discussed. Effective tailored psychosocial weight services, which are adapted for the cognitive deficits often experienced by this population, will be presented. These can be delivered by individuals with minimal training in the manualized treatment. Delivery methods that reach patients outside the clinic, reducing clinic and clinician burden, including web-based and mobile app delivery will be presented. Utilization of peer wellness coaches to increase motivation and outreach between appointments will be discussed. Family involvement in the effort will be described.

Suicide Risk Assessment in the Emergency Room: When Is Involuntary Admission Helpful?

Chair: Nazanin Alavi, M.D.

Presenters: Taras Romanovyc Reshetukha, M.D., Archana Patel, M.D., Megan Anne Yang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand suicide risk predictors that are most important in decision making in the emergency room and the ones that are commonly missed; 2) Educational intervention and introduction to a suicide prompt for remembering the suicide risk predictors that are commonly missed; 3) Understand the advantages and disadvantages of involuntary admission and its effect on patient-physician relationship; and 4) Understand the advantages and disadvantages of involuntary admission and its effect on patient-physician relationship

SUMMARY:

Suicidal behaviour including attempts and harm to self, remain the most common reasons for presentation to the emergency rooms or psychiatric clinics. Perhaps the most frequently examined topic in the field of suicidology, is the degree to which death by suicide can be predicted. In spite of identifiable risk factors, completed suicide remains essentially unpredictable by current tools and assessments. Moreover, some suicide risk factors may not be included consistently in the suicidal risk assessments in the emergency room by either

emergency medicine physicians or psychiatrists. There continues to be a lack of clarity on how to assess individual cases for suicidal risk. Though a surfeit of information regarding patient risk factors for suicide is available, clinicians and mental health professionals face difficulties in integrating and applying this information to individuals, in order to come up with a management and follow-up plan. At the time of suicide risk assessment, one of the most common questions asked is how helpful involuntary admission is in decreasing risk of suicide? Involuntary hospitalization in those with suicidal ideation has been a common practice for many years and in many societies. Granted that an involuntary hospitalization is at least an unpleasant experience for many patients, the question is that what are the positive results for them? Although these patients need attention regarding their mental illness, the question is how much these patients will benefit from involuntary admission and what the long-term outcome would be. This workshop is supported by evidence from our studies that looks into main predictors of imminent suicidal behaviour based on physician's opinion, chart review and brief educational interventions with the aim to improve suicide risk assessment and also study on patients and physicians opinion on involuntary admission. In didactic component of our workshop we will review general approach to suicide risk assessment, address risk factors that are considered important by Emergency Physicians and Psychiatrists when assessing Suicide Risk and their opinion about what factors influence their decision while assessing these patients. Suicide predictors that are commonly missed at the time of assessment. Presenters will introduce a tool "Suicide RAP (Risk Assessment Prompt)" aimed to help physicians remember the important suicide risk factors that are commonly missed in the assessments. We will also provide an overview of evidence-based interventions that reduce suicide risk. We will then discuss advantages and disadvantages of involuntary admissions and discuss that patients' characteristic and treatment component could be some of the differences of their satisfaction outcomes. Accordingly, through the recognition of these factors, new treatment approaches could be utilized.

Sustaining Remission of Psychotic Depression: The STOP-PD II Study

Chair: Alastair Flint, M.B.

Presenters: Anthony Joseph Rothschild, M.D., Patricia Marino, Ellen M. Whyte, M.D., Benoit Henri Mulsant, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the challenges in treating psychotic depression in both younger and older adults; 2) Understand the rationale, design, and methodology of STOP-PD II; and 3) Understand the risks and benefits of continuing antipsychotic medication beyond remission in persons with psychotic depression

SUMMARY:

Psychotic depression (PD) is a challenging disorder to manage. Acute episodes of PD are frequently characterized by severe morbidity and disability, especially in older individuals; the rate of mortality exceeds that of non-psychotic depression. Moreover, relapse and recurrence are common. Treatment guidelines recommend either electroconvulsive therapy or the combination of an antidepressant drug and antipsychotic drug for the acute treatment of PD. However, little is known about the continuation treatment of PD. Of note, it is not known whether antipsychotic medication needs to be continued once an episode of PD responds to combination pharmacotherapy. This issue is of great clinical importance. On the one hand, premature discontinuation of antipsychotic medication has the potential risk of early relapse of a severe and potentially lethal disorder. On the other hand, the unnecessary continuation of antipsychotic medication can expose a patient to adverse effects, such as weight gain and metabolic disturbance. This symposium will report for the first time the results of a NIMH-funded, multicenter randomized placebo-controlled trial (STOP-PD II) that assessed the risks and benefits of continuing antipsychotic medication in 126 younger and older adults with PD once the episode of depression had responded to treatment with an antidepressant (sertraline) and an antipsychotic (olanzapine). In addition, findings of a separate NIMH-funded study that used magnetic resonance imaging to compare the effects of

olanzapine and placebo on brain structure and connectivity in STOP-PD II participants will be presented; this is the first placebo-controlled RCT to examine the effect of an antipsychotic medication on brain structure and connectivity in humans. The principal finding of STOP-PD II was that time to relapse was significantly shorter in participants randomized to sertraline and placebo (monotherapy) compared to those randomized to continue sertraline and olanzapine (combination therapy); the frequency of relapse in these groups was 54.8% (n=34/62) and 20.3% (n=13/64), respectively. There was a significant difference between randomized groups in the trajectories of weight and total cholesterol, with a decrease in these variables in the monotherapy group and an increase in weight in the combination therapy group. The groups did not significantly differ in the trajectory of plasma glucose, with a slight decrease in both groups. Participants who sustained remission with combination therapy had a significant reduction in cortical thickness compared to participants randomized to monotherapy. Participants in the monotherapy group who had a relapse also experienced a reduction in cortical thickness. Our session will conclude with a case vignette that highlights the challenges raised by the findings of STOP-PD II in managing psychotic depression and will provide a springboard for participants to share their own experience in the management of this disorder

Tailored Suicide Prevention Approaches for Asian Americans

Chair: Hochang Benjamin Lee, M.D.

Presenters: Rona Hu, M.D., Su Yeon Lee-Tauler, Albert S. Yeung, M.D.

Discussant: Dora-Linda Wang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To demonstrate the intersection between cultural and structural stressors, mental illness, and suicidal thoughts and behaviors among Asian Americans.; 2) To understand sociocultural and systematic barriers to mental health service use among Asian Americans with mental illness and suicidal thoughts and behaviors.; 3) To identify culturally-tailored

community outreach, psychoeducation, and mental health treatment strategies for Asian Americans.; and 4) To demonstrate the effectiveness of culturally- and structurally-informed strategies for engaging and treating Asian Americans in primary care and community settings.

SUMMARY:

Asian Americans are the fastest growing racial and ethnic group in the United States, particularly in large cities represented in this panel's study sites (Washington D.C., Boston, New York City, and San Francisco). Suicide is the 8th leading cause of death among Asian Americans, compared to the 11th leading cause of death for all other racial groups. Asian American older women have the highest suicide rate of all other racial and ethnic older women, and Asian American college students are more likely than non-Hispanic White students to experience suicidal thoughts and attempts. Yet, Asian Americans are least likely to seek help from professional mental health providers of all other racial and ethnic groups. Instead, Asian Americans with emotional needs tend to seek help from primary care physicians, faith-based leaders, or alternative medical practitioners. This session will present results from epidemiological studies on the prevalence and predictors of depression, suicidal thoughts, and mental health service use. The presenters will address how Asian Americans conceptualize and express mental illness and suicidal thoughts and behaviors. Further, the presenters will discuss common barriers to mental health service use, including stigma associated with mental illness, financial burden, and lack of linguistically-, culturally-, structurally-appropriate treatment options. This session will showcase various efforts to develop community outreach, psychoeducation, partnership with faith-based leaders, and culturally-tailored Collaborative Care Model in primary care setting. These efforts include: (1) the Center for Research on Cultural and Structural Equity in Behavioral Health's development of a psychoeducational and contact video tool to address the stigma of mental illness, increase awareness on mental health issues, and improve help seeking and suicide prevention among Korean Americans; (2) Stanford University's Parent Playbook that uses role-playing to help parents foster deeper and meaningful relationships with

their children; (3) the Culturally Sensitive Collaborative Treatment (CSCT), a Collaborative Care Model with an added cultural component to assess patients' illness beliefs and to engage patients with tailored treatment for Chinese immigrants in primary care setting; and (4) community-based strategies to outreach and deliver mental health services for Korean immigrant older adults. At the end of the session, participants will recognize the importance of tailoring community outreach and psychoeducational efforts, address systematic depression screening of Asian Americans in primary care settings, and understand how to conduct culturally sensitive interviews to engage Asian Americans in treatment. The speakers will consist of psychiatrists and public health researchers who will present historical perspectives, qualitative and quantitative findings, and suicide prevention efforts.

Taking the Wheel: Psychiatrists' Role in Patient Driving

Chair: Brian James Holoyda, M.D., M.B.A., M.P.H.

Presenters: Jacqueline Landess, M.D., J.D., Eric Chan, M.D., Vivek Datta, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of various psychiatric disorders and psychotropic medications on patients' driving ability; 2) Describe areas of potential psychiatric liability due to patients' risky and dangerous driving; 3) Demonstrate knowledge of current legal statutes for driving while under the influence of cannabis; and 4) Provide recommendations regarding psychiatric informed consent and documentation when a patient is at risk for impaired driving

SUMMARY:

Driving is a complex task that involves various mental functions including attention, concentration, visual and auditory perception, and fine and gross motor control. It is therefore not surprising that mental illness, psychotropic medications, and substance use can have profound effects on patients' driving ability. In this session we explore the evidence regarding the impact of mental illness on driving, describe a classification scheme for medications' impact on driving of which all

psychiatrists should be aware, discuss the relationship between cannabis use and driving, and delineate areas of potential physician liability for patients' driving-related risk of harm. A growing body of literature indicates that psychiatric disorders such as mood disorders, psychotic disorders, and dementia can have a deleterious impact on patients' driving-related capabilities. In some cases, the presence of a mental illness, even treated, may have a demonstrable effect on driving. Psychiatrists should be aware of the relationship between various mental disorders and driving-related abilities to be able to properly educate patients regarding the associated risks. Psychotropic medications and other drugs can also have a major impact on patients' driving ability. The International Council on Alcohol, Drugs and Traffic Safety (ICADTS) has developed a classification system of all medications to identify those most likely to increase a patient's risk behind the wheel. With the increasing legalization of cannabis for recreational and medicinal purposes, there is likely to be a rise in the number of individuals driving in the setting of cannabis use. The route of administration, potency of the strain, an individual's metabolism, and a host of other factors may affect how cannabis impairs a patient's driving. It is therefore increasingly important for psychiatrists to assess patients' medication use and cannabis intake to identify the potential for hazardous driving and to counsel patients accordingly. Though a critical activity in many patients' lives, driving is a frequently overlooked area of potential clinical impairment. In 2016 the American Psychiatric Association published a position statement indicating that psychiatrists do have a role in advising patients about the potential effects of illness and medications on their driving ability but noted that the ultimate authority for assessing driving resides with the Department of Motor Vehicles. Despite this opinion, psychiatrists and other physicians have been held liable for patients' driving-related risk of harm to others in various legal cases. By utilizing a combination of media, didactic instruction, and straw polling, we will engage the audience throughout our review of the impact of mental illness, medications, and cannabis on patient driving. We will assess participants' knowledge regarding relevant legal cases involving patient driving and assess their opinions regarding the outcome of these cases.

**Team-Based, Measured Care in CMHC Environment:
Lessons Learned From Integrated Care in Primary
Care Settings**

Chair: Jules Rosen, M.D.

Presenter: Michelle Hoy

Discussant: Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. The audience will describe how team based care can be adapted to their work environments.; 2) Participants will describe how measurement based care can be used to guide their treatment plans.; 3) Participants will describe the relative advantages and disadvantages of self-ratings vs. clinician ratings.; and 4) 4. The audience will engage in real-time exercise to develop a staffing model an integrated, team-based clinic using a computer program developed for this process.

SUMMARY:

Despite the established benefit of non-pharmacological therapies for mood disorders, treatment plans of prescribers and non-prescribers in Community Mental Health Centers (CMHC) are not coordinated to address individual needs based on illness severity, acuity or patient preference. To address this, we created "integrated" team-based clinics in our CHMC in Western Colorado. Patients are assigned to a clinic which includes a psychiatrists, nurse practitioners, psychotherapists, case managers and peers. All clinic patients can check-in weekly, and may also have specific therapy, case management, peer, or med management appointments. We proposed that coordinated and intense care during an acute phase of illness will result in faster improvement and reduced overall resource utilization. Our initial clinic focused on mood disorders. As patients enter the clinic, they meet with team members to discuss treatment modalities based on symptom severity and preference. Resources are prioritized for patients in the "acute phase", defined as PHQ9 scores > 10. After 15 months, 109 patients have enrolled in the clinic, with 84 completing at least 6 weeks. The initial mean PHQ9 score was 20.2 (range 14 – 26); and by week 12 the mean score was 12.3 (range 3 – 23). The

drop-out rate, defined as clinic attendance two times or less in the first 6 weeks without further follow-up, was 25%. As patients move from acute phase to continuation / maintenance phase, treatment plans are modified by reducing individual appointments and promoting group participation. By week 6, 61.5% of patients were no longer in the acute phase and 73.1% by week 12. Mean time spent per patient until resolution of acute phase or week 12 (whichever came first): medical provider: 0.9 hrs; therapy: 1.9 hrs; case management: 1 hr; peers: .55 hrs. All patients in acute phase are discussed weekly in a team meeting, and those who are not showing improvement after 8 weeks are reviewed intensively. In terms of resource utilization, this four hour weekly clinic has 8 hours of provider time (2 providers) and 8 hours of therapy (2 therapists), can admit 4 – 5 new patients per week and see an additional 6 – 8 patients weekly as follow-up visits. In a typical CMHC setting, patients are scheduled for either therapy or medication management based on availability of the clinician, rather than what each patient needs. Assigning resource utilization based on objectively measured patient acuity has enabled us to create computer-generated models of staffing for mood disorders, SPMI, and other diagnostic categories. Providing intense, weekly care for patients in acute need has resulted in more rapid improvement and less resource utilization compared to typical pattern scheduling visits based on clinicians' schedules.

**Ten Neuropsychiatrists Who Changed American
Psychiatry**

Chair: Sheldon Benjamin, M.D.

Presenters: Barbara Schildkrout, M.D., Lindsey MacGillivray, M.D., Kathy Niu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Name several American psychiatrists who also studied neurology and describe what their major contributions were to the field of psychiatry; 2) Articulate a few of the major scientific questions that faced the psychiatric community in the 19th and 20th centuries; and 3) Trace the historical origin of some modern neuropsychiatric principles

SUMMARY:

Psychiatrists who were also trained in neurology or neurological sciences were responsible for major advances in medicine and psychiatry throughout the 19th and 20th centuries. These dual trained psychiatrists created paradigm shifts that influenced the course of American psychiatry and had an impact on the direction of the Association of Medical Superintendents of American Institutions for the Insane; its successor, the American Medico Psychological Association; and its successor, the American Psychiatric Association. In honor of the 175th anniversary of the APA, we will review the contributions of some of these great American neuropsychiatrists. We identified fifty-nine 19th and 20th century neuropsychiatrists who had major impacts on medical science, fifteen of whom worked for part or all of their careers in the United States. We examined the trends in American psychiatry that were extant at the time these neuropsychiatrists worked, and we sought to understand the impact of their work on developing psychiatric thought. In this symposium we will present brief biographical sketches of ten American neuropsychiatrists, setting each one in the context of medical practice and psychiatric thought at the time each lived. Emphasis will be placed on the major contributions for which each was known. The work of Albert Moore Barrett, Stanley Cobb, Solomon Carter Fuller, Kurt Goldstein, Smith Ely Jelliffe, Adolf Meyer, S Weir Mitchell, Abraham Myerson, John Romano and Edwin Weinstein will be presented. The brief biographical presentations will be interspersed with information to help in understanding historical context, such as: the “family tree” of their training pedigrees in relation to one another, short explanations of the history of major threads of scientific thought, and modern psychiatric trends that follow from their ideas. The influence of each on the APA and its predecessor organizations will be highlighted to the extent known. During the discussion, participants will join in an interactive historical game with the goal of reinforcing the material presented: the major contributions of each figure and the overarching historical narrative.

Test Your Knowledge Psychiatry Quiz Game Round**2**

Chairs: Ana T. Turner, M.D., Robert N. Averbuch, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and Describe DSM5 criteria for both high and low frequency psychiatric diagnoses; 2) Describe pathophysiology, epidemiology, and treatment of various psychiatric diagnoses; 3) Explain the identification and treatment of psychiatric emergencies; 4) Identify important historical facts in the field of psychiatry; and 5) Express novel ways to remember differentials and treatment algorithms

SUMMARY:

Ever wonder how you would fare on MindGames but too shy to have your knowledge tested in front of an audience? Then come enjoy a 90 minute workshop that will allow you to answer Psychiatry Questions anonymously and compare your knowledge to your peers. This is the second round of the game that was first aired at the 2018 APA Annual Meeting, so expect to face new and intriguing challenges! Studies have noted that human learning is based in part on reinforcement and that competition between groups of learners increases the level of participation. When studied in the fields of mathematics and computer science, competitive games were also noted to promote greater interactivity, collaboration within groups and increased motivation for self-directed learning. Thus, we propose a 90 minute highly interactive workshop to quiz attendees on various aspects of the field. We will utilize novel mnemonics, video clips, and visual aids to help audience members learn key differentials and treatment algorithms, frequently and infrequently encountered diagnostic criteria, pathophysiology, epidemiology, and treatment of various psychiatric diagnoses and psychiatric emergencies, as well as important historical facts in the field of psychiatry. We will also explain how to create your own quiz for use in teaching. This quiz game offers audience members a chance to anonymously test their knowledge compared to the entire group via PollEverywhere software, allowing them to self-assess where their medical proficiencies and deficiencies lie, all the while reviewing important concepts of psychiatry.

The Beginner's Guide to Starting a Psychiatry Residency in a Non-Academic Setting

Chair: Rodney Anthony Villanueva, M.D.

Presenter: Krystle Graham, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the recent trends in the numbers of psychiatry residency programs and numbers of medical students matching in psychiatry residencies.; 2) Identify the steps involved in establishing a new psychiatry residency program in a non-academic facility.; 3) Recognize the challenges in changing the culture of a facility that is non-academic and productivity driven into one that is oriented to the teaching and formation of psychiatry residents.; and 4) Evaluate the current gaps in psychiatry residency training that are to be addressed in order to better prepare residents for a career in psychiatry.

SUMMARY:

The number of new psychiatry residency programs has been increasing rapidly in recent years. According to the Accreditation Council for Graduate Medical Education, there were twelve new psychiatry residencies accredited between 2012 and 2015. Between 2015 and 2018, fifty-six new programs were accredited. This increase in new residencies recognizes the growing number of Americans diagnosed with mental illness, the shortage of psychiatrists, the need for psychiatric services in rural and urban underserved areas, and the larger numbers of medical students matching in psychiatry residencies. Establishment of a new psychiatry residency is a highly involved process that entails the development of infrastructure, curriculum, rotation schedules, faculty development, and funding procurement. This task is even more demanding when the residency is established in a facility that has never worked with residents, is not academically oriented, and is productivity-driven by the relative value units earned by the staff. The authors of this session were faced with such tasks in 2015 at their behavioral health facility in Charlotte, North Carolina. While this session will cover practical information on starting a new psychiatry residency program, it will focus on the unique challenges and opportunities when establishing a psychiatry

residency in a non-academic, productivity-driven setting. These challenges include changing the culture of the institution to make it conducive to resident learning, connecting with community resources to address the gaps in faculty expertise, recruitment of faculty participation with the competing interest of productivity, and recruitment of qualified applicants to a new residency. The session will also present the ongoing struggles a new psychiatry residency program faces in its early years. There will be a breakout session in which participants will identify current gaps in psychiatry residency training and how these should be addressed in order to prepare psychiatry residents for future practice. The authors will discuss how starting a new program and being in a non-academic facility facilitated or hindered their efforts to address these training gaps. Psychiatry residency programs are no longer the sole purview of large academic institutions. In response to the growing mental health needs of the American population, non-academic institutions must now become involved in the formation of psychiatrists. Non-academic institutions provide a distinctive environment of learning that will fill the need for greater access to mental health care. Those psychiatrists and administrators of non-academic institutions must come to an appreciation of the critical role they have in the future of the profession and the need to do what they can to advocate for residency training.

The Healing Charms, Tricks, and Secrets of Nature: An Opportunity for Mental Health Professionals to See What We Have Been Missing

Chair: Lise Conway Van Susteren, M.D.

Presenters: Joseph John Lancia, D.O., Alexander Peter Schrobenhauser-Clonan, M.D., M.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the science: how nature improves cognition, memory, impulse control; and reduces anxiety and depression; how natural space in urban areas is especially beneficial to at-risk populations.; 2) Describe how our relationship with animals can deepen the healing process - identifying our own emotional (sometimes unconscious) responses to this issue; what we can learn from indigenous cultures; 3) Identify our

evolutionary underpinnings: microbiomes, soil, circadian rhythm etc. and the scientific case for going to bed with nature getting “dirty” in daylight!

4. Describe biophilia: how it affects our mental well-being and why, where and how we can advocate for it.; and 5) Describe the neuroscience: the “me-definer”, the “awe-inspirer” sites and how upliftingly restorative experiences outside of ourselves may be undermined by the consuming presence of technology.

SUMMARY:

Experimental, epidemiological and observational study of the health impacts of nature exposure has increased in recent years, inversely to an overall population trend of decreasing connectedness to and time spent in nature-rich spaces. As a result of accelerating population growth, expanding urbanization, environmental pollution and degradation, the allure of technology and its consequences, nature is on the run – and so are we. Psychiatrists should be aware of the considerable existing evidence of these effects and the future directions of research. We must accept the imperative to promote personal, local and international climate-change related actions that can have positive mental health co-benefits through the conservation, preservation and rehabilitation of green spaces and larger ecosystems. This workshop will identify the many charms, tricks, and secrets that nature possesses to heal and promote physical and psychological health. We will demonstrate the science that supports these nature-derived impacts. From Phytoncides that boost the immune system and help us fight cancers and viruses, to the science of psychoacoustics and why the sounds of brooks and birds and the winds in the trees are comforting, to the critical role of intestinal microbes in the production of neurotransmitters, to the 2017 Nobel prize winning studies showing that every cell in our body has an internal clock governed by our circadian rhythm, we will see the advantages of living in harmony with nature. We will examine how to have a healthy and more respectful relationship with our larger world, emphasizing natural systemic remedies: the expansion of green space, seeking deeply healing relationships with animals, and nonpharmacological methods to manage anxiety and

protect brain tissue. As mental health professionals, we are uniquely qualified – trained in science, skilled at influencing others to change, and dedicated to restoring health. We have experience visualizing how the choices we make today shape the health of our ourselves and communities into the future. We understand how using our personal sense of responsibility to take action can turn feelings of helplessness into empowerment – and create resilience in challenging times. This workshop will help us to be more confident educators of the general public and other health professionals, advocating for wise policies and practices, recognizing that the world needs enlightened healers now more than ever.

The Importance of Psychological Evaluations in U.S. Asylum Cases: How to Start Your Own Asylum Clinic

Chair: Jon Wesley Boyd, M.D., Ph.D.

Presenters: Katherine Peeler, M.D., Nikhil Patel, M.D., M.P.H., Robert P. Marlin, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process of offering and performing forensic asylum evaluations and the significance of a psychological evaluation in the outcome of an asylum case; 2) Describe how asylum seekers with mental illness face disadvantages with respect to credibility determinations in U.S. immigration courts; and 3) Consider ways of creating and implementing an asylum clinic

SUMMARY:

Issues of immigration and asylum are vitally important given present world events as well as the current US administration’s rhetoric about, and approach to, immigration. In general, asylum seekers have significant trauma exposure and are at high risk for developing post-traumatic stress disorder. Psychiatrists can assist asylum seekers and immigration courts by performing psychological evaluations, acting as expert witnesses, and providing corroborating evidence of trauma. Additionally, psychiatrists can present information about how trauma can create difficulties in recalling events accurately or hinder one’s ability to speak about traumatic events, which is important given

that asylum seekers are expected to testify about their experiences. The overall success rates of asylum seekers in gaining legal status is about 30%, but when an evaluation is performed to support the client, 90% of cases are successful. The presenters, which include attending physicians who developed asylum clinics at their hospital and their medical school and a psychiatry resident who has participated in these evaluations, will discuss nuances of working with this population and offer ways of creating and implementing asylum clinics. Given both the drastic increase in traumatized refugee populations and the current political climate in the US, this information is both topical and important.

The Military Deployment Formulary: Medication Management and Resupply Through Changing Battlefields

Chairs: Daniel R. May, D.O., Connie Thomas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the impact of the deployment environment and levels of medical care on the mental health of military service members.; 2) Identify constraints on medication management during military deployment.; 3) Discuss methods that military psychiatrists have used to navigate a limited formulary while still providing high quality patient care.; and 4) Participate in an interactive, case base discussion of medication management in austere environments.

SUMMARY:

The goal of deployment behavioral health is to maintain the readiness of the force even in austere conditions. Regardless of military branch, medical care that is closer to combat conditions is restricted due to the small size of units, location, and/or necessity to move under changing battlefield conditions. Medication inventories are determined in advance and the selection of behavioral health medications tends to be narrow in order to have more accessibility to immediately life-saving treatments. In addition, some medications require specific storage requirements which limit their use. Soldiers are often prescribed a time-limited supply of medications for pre-existing conditions, which will

need to be renewed while deployed. Soldiers can enter the deployment theater with a prior mental health condition or develop a new condition while deployed due to geographical separation from family, environmental problems, or stressors specific to their experience. Changes in medication or treatment of newly identified conditions may become problematic with a limited formulary. Our presentation will introduce members to the challenges of medication management while deployed through interactive, case-base examples. We will identify methods psychiatrists have used in order to navigate the difficulties of medication resupply while deployed. This presentation will be useful to both civilian and military providers because it will encourage revitalized perspectives on medications and innovative ways of managing complex patient cases.

The Use of Narration by Physicians: An Engaging Tool for Social Healing

Chair: Caroline Giroux, M.D.

Presenters: Amy Barnhorst, M.D., Rajiv Misquitta, Steven Paul Nemcek

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participant will list 3 advantages of narration in medicine for the population in general and 3 for physicians in particular.; 2) 2. At the conclusion of this session, the participant will be able to identify effective communication strategies to initiate dialogue for social change and healing.; 3) 3. At the conclusion of this session, the participant will be able to utilize media as a way to increase health literacy, break isolation, prevent burnout and boost resilience factors.; and 4) 4.

At the conclusion of this session, the participant will be able to list strategies to incorporate narration in clinical settings.

SUMMARY:

Written or oral narration can support self-preservation and general well-being. The life story is an internalized and evolving myth of the self, which provides unity and purpose in the individual's life [1]. Hence, it is easy to realize how storytelling is a universal need of the humankind. Doctors are no

different, even though their “storylistening” role can seem prominent in their daily practice. Physicians should practice such modalities for the benefit of the people they treat but also their own, as stories also heal the healers. Whenever they document an assessment or do a case presentation, they tell an important story. When they engage in psychotherapy with their patients, they co-create stories. And stories can help a person create meaning and heal. Narrative therapy is used for people who have suffered trauma [2]. Life review therapy explores problems through narration and was developed for older populations. The function of a story in educating society contributes to the evolution of consciousness which can bring global, deep and positive change. Writing in any form (poetry, essay, narratives, etc) is a great leverage because it gives doctors a voice within a complex system where they often feel disempowered. It also allows them to process difficult experiences. It is a way to share patients' stories and how they intersect with their mission. It is a platform to advocate for patients and buffer social injustices. Used effectively, narration in the media can bring people together and lead to change. The speakers will discuss their own media experience (including publication in newspapers, podcast etc), how the medical field can be incorporated into the media, and vice-versa. They are also active in the Sierra Sacramento Valley Medical Society, which mission consists of building a stronger, more unified healthcare community within three different counties. They will use their official journal, the Sierra Sacramento Valley Medicine (SSVM), as an example of vehicle for storytelling. SSVM promotes the history, art and science of medicine, the protection of public health and the well-being of patients. It provides a forum for local physicians and healthcare professionals to share their knowledge about medicine and express their views on issues impacting the medical profession. The Society also recently launched a Joy of Medicine podcast which is an example of medical journalism revitalizing the field. Through communication of issues important to physicians and their patients, various specialties can dialogue and work towards common goals: improving practices for their patients' well-being, optimizing work conditions for their own well-being, and discovering joy throughout their journey. The society also uses another

storytelling tool called “lightning grand rounds” at their annual Joy of Medicine summit where physicians can articulate in a quick, insightful manner what joy in medicine feels, looks, and sounds like to them.

Thud: A Critical Reexamination of the History and Ethics of Rosenhan’s Experiment “On Being Sane in Insane Places”

Chair: Dominic Sisti, Ph.D.

Presenters: Andrew T. Scull, Ph.D., Susannah Cahalan, Jonathan Moreno, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the context within which Rosenhan conducted his study and the historical import of “On Being Sane in Insane Places”; 2) Describe details about the study and discuss concerns about both its validity and ethics; and 3) Discuss the impact of the Rosenhan study on psychiatric treatment and nosology

SUMMARY:

This session has been canceled.

To Write or Not to Write: Ethical Issues for Clinicians Writing Fiction, Personal Narrative and for Popular Media

Chair: Shaili Jain, M.D.

Presenter: Nathaniel Morris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify relevant ethical issues for clinician writers; 2) Explore the vulnerability of patients, healthcare professionals and others when clinicians become authors; 3) Propose a framework for providing ethical guidance to prospective clinician authors; and 4) Using case scenarios, identify which ethical issues and conflicts are raised under different circumstances

SUMMARY:

Never in the history of medicine has patients' confidentiality and medical professionalism been so scrutinized and regulated. This climate rightfully raises ethical dilemmas for any clinician who writes about his or her profession for a lay audience.

Writing remains a powerful medium via which mental health professionals can engage with the public. Moreover, since mental illness remains inaccurately portrayed and stigmatized in popular culture, it is vital that mental health professionals continue to interact with the public via this medium. The advent of the digital age has only added to outlets where mental health professionals can publish their writing. Beyond novels, memoirs, newspapers and magazines, clinician writers can now choose from websites, social networking sites and blogs. Mental health professionals should be encouraged to write and serve as educators and advocates for their patients and the profession. However, there are many ethical issues to consider if clinician writers want to avoid the pitfalls of engaging in this activity and effectively innovate in the ever-expanding arena of medical communication and commentary. Our session will introduce participants to the major ethical issues encountered when writing for lay audiences: clinician obligation to primacy of patient welfare; to do no harm; to preserve patient trust in the clinician patient relationship and manage conflicts of interest. These points will be emphasized through the sharing of real world examples. We will also share practical tips and strategies for addressing such ethical conflicts and how to avoid them in the first place. We will share several case scenarios and engage the audience in a discussion of which ethical issues and conflicts are pertinent to each case.

Toward Youth-Friendly Mental Health Care: Reach Out, Engage, Win

Chair: Anna Szczegielniak

Presenters: Justo Pinzon Espinosa, Marcos Imbago

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the lack of meaningful youth engagement in the process of planning, implementation and evaluation of adolescent & youth-friendly mental health programs as a significant global problem.; 2) Come up with three possible strategies to reach out and engage adolescents & young people.; 3) Come up with three international mechanisms that may be useful when advocating for the provision of age-sensitive mental healthcare.; and 4) Discuss the role of psychiatric

trainees in shaping more rights-based approaches for adolescent & youth-friendly mental health programs and services.

SUMMARY:

Attitudes towards mental health have changed significantly within the last two decades thanks to the joint effort of both national and international agencies with a strong focus on the prevention and de-stigmatization of the healthcare services across different regions and age groups. Unfortunately, mental health resources are not allocated equitably worldwide, and discussions regarding distribution patterns are taking place consequently without meaningful input from various key stakeholders. Among the missing participants are adolescents and young people, even though they represent a quarter of today's population. The mental health of adolescents and youth has not been a priority for many decades as this group was mostly perceived as being generally healthy and as a homogenous mass that didn't require to be targeted by dedicated policies or prevention programs. Repeatedly reported lack of qualified healthcare professionals and facilities tailored to the very needs of this diverse group, low support from the community level, and lack of integration of mental health issues to the primary health care are the everyday struggles to many young people seeking help. There are also certain key groups who are rarely addressed: indigenous peoples, populations experiencing discrimination and human rights violations, people with addictions, diverse SOGIESC people and other underserved populations. During the session we aim to discuss the current state of adolescent mental health programs with emphasis on meaningful youth engagement in the process of planning, implementation and evaluation of these programs from the global perspective. We hope to open the discussion on how to reach out and engage this set of actual and prospective users in designing proper prevention programs, as well as making services available for this particular age group with focus on international mechanisms that would encourage participants to share their own experiences from work. The core of the session is a panel discussion that would incorporate perspectives of service providers, mental health advocates, and the youth representatives discussing gaps and possible

solutions with a strong human rights approach. We believe this session may raise awareness of how little users of certain age were part of the discussion on mental health prevention and services and show what kind of benefits reaching out to them may bring. An interactive session like this embodies very well the spirit of the APA 2019 Annual Meeting Theme “Revitalize Psychiatry: Disrupt, Include, Engage, and Innovate” and opens the floor for further discussions with national and local scopes and possible changes in existing models. The session is under auspicion of the European Federation of Psychiatric Trainees.

Training the Next Generation of Community Psychiatrists: Science and Recovery

Chair: Paul J. Rosenfield, M.D.

Presenters: Stephanie Le Melle, M.D., M.S., Joy Jiwon Choi, M.D., Ludwing Alexis Florez Salamanca, Tomas Felipe Restrepo Palacio, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify qualities and roles of a successful modern community psychiatry practitioner; 2) Learn how to engage trainees through innovative curricular strategies for teaching about community psychiatry; and 3) Start to work on creating or enhancing your own residency program's training in community psychiatry

SUMMARY:

The US is facing a shortage of psychiatrists, and especially psychiatrists who are trained to provide care to individuals with mental illness in community settings, from public clinics and hospitals to ACT teams and jails (Satiani 2018, Sowers 2011). Residency programs have an important role to play in recruiting psychiatrists into the public sector, and training them to be effective clinicians and advocates (LeMelle 2014). In this workshop, we will identify the qualities and roles of successful community psychiatrists, demonstrate innovative training strategies that inspire and engage trainees, and help participants work on plans for enhancing their own training programs.

Trauma Inflicted to Immigrant Children and Parents Through Policy of Forced Family Separation

Chairs: Nubia Amparo Chong, M.D., Gabrielle L. Shapiro, M.D.

Presenters: Eraka P. Bath, M.D., Judy London, J.D.

Discussant: Lisa Roxanne Fortuna, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • Understand the rapidly changing immigration laws during the period of family separation and reunification.; 2) • Develop a more thorough understanding of the challenges faced by immigrant families during the process of family separation and reunification.; and 3) • Understand the effects of forced separation on immigrant parents, and children at different developmental stages.

SUMMARY:

On May 7, 2018, it was announced that a “zero-tolerance” policy of forced family separation would be in effect to deter migrants from crossing the southern border of the United States. Within the first month, nearly 3,000 children were separated from their parents while crossing the border (1). To put this into perspective, it is estimated that less than 2000 cases of family separation occurred between October 2016 and February 2018 (2,3). After being separated, children were sent to shelters and other temporary housing, often hundreds of miles away from their parents. The American Psychiatric Association (APA) joined the American Academy of Pediatrics (AAP), the American Association of Child & Adolescent Psychiatry (AACAP), and 11 other healthcare organizations to quickly denounce the policy of family separation. The APA was a leader in the efforts, and in May 2018 President Altha Stewart, M.D stated, “Children depend on their parents for safety and support. Any forced separation is highly stressful for children and can cause lifelong trauma, as well as an increased risk of other mental illnesses, such as depression, anxiety, and posttraumatic stress disorder (PTSD). The evidence is clear that this level of trauma also results in serious medical and health consequences for these children and their caregivers (4).” The AACAP published a policy statement June 2018 that explained, “As child and adolescent psychiatrists, we recognize that parental support is an essential and proven factor for protecting children and helping

children recover from the negative impacts of stress and trauma. Maternal support has been shown to strengthen neuroprotective factors in the brain during childhood when children's brains are most vulnerable. Separating children from their families in times of stress can place children at heightened and unnecessary risk for developing potentially serious and long-lasting traumatic stress reactions, at the very time when they are most in need of care and support (5)." The executive order of June 20th, 2018, terminating the policy enforcing separation of families, did not end the suffering of parents and children that were already separated and failed to provide any remediation for the devastation unnecessarily inflicted by the policy (6,7). As a response to this, immigration lawyers at Public Counsel and Sidley Austin LLP filed a class action lawsuit supported by expert declarations from over a dozen of the nation's leading trauma experts (8). This interdisciplinary presentation will begin with a review of three cases detailed in the class action lawsuit. The second portion, will explain the pertinent laws and provide first-hand accounts of working with clients who were separated in detention. The third portion will review the potential effects of this kind of trauma on both parents and children, including a discussion of the potential effects of trauma of children at various stages of development.

Treating Black Children and Families: What Are We Overlooking?

Chair: Sandra Walker, M.D.

Presenters: Beverley Elaine Allen, M.D., Sarah Yvonne Vinson, M.D., Carl Compton Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn how to ask women the right questions about whether or not they were doing social drinking before they knew they were pregnant.; 2) Know the multiple ways people in cultures drink and expose their unborn fetus to alcohol; 3) Identify interventions to enhance psychiatric health through nutrition.; 4) Review current service gaps for child and adolescent mental health services.; and 5) Identify potential benefits of integrated care for African American youth.

SUMMARY:

The Black Psychiatrists of America, formed 50 years ago by black members of APA, holds conferences, both in the US and throughout the African Diaspora, devoted to consideration of problems facing black and under-served patients, families, and mental health workers. Recognizing that many patients of color are treated by people of races, ethnicities and colors different from their own, this session will focus on three presentations that have been well received recent BPA meetings. They address issues of in utero alcohol exposure, inadequate micro nutrition, and challenges in collaboration with other clinical providers that, if properly addressed, can have positive impact on the mental health and well-being of black children and families—indeed, on children and families in general.

Unscripting: Using Improvisational Theater to Move Beyond Personal Limitations

Chair: Jeffrey W. Katzman, M.D.

Presenter: Peter Felsman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply basic ideas from improvisation to reconsider old life patterns and to challenge ourselves as clinicians; 2) Apply the ideas of improvisation to work with a variety of different patients; and 3) Understand the value that improvisational theater can be as an adjunctive treatment

SUMMARY:

Thousands of individuals across the world participate in improvisational theater – some for fun, some for community building, some to stimulate their creativity. Most are not actors. The Applied Improvisation Network and Global Improvisation Institute now have memberships of over 10,000 individuals with scores of practitioners and conferences around the world. What is this applied improvisation, and can we and our patients benefit from the premises and practices of improv? This workshop will explore a variety of applications of improvisation. This will include work with scientists as developed at the Alan Alda Center for Communicating Science to help seasoned academicians deliver their message and reconnect to

their passion. We will explore the use of improvisation with clinicians including medical students, psychiatry residents, and seasoned psychotherapists to understand how training in improvisation can make a better practitioner. We will share information about work with various patient groups including patients with serious mental illness, Vietnam Veterans with PTSD, and patients with Parkinson's Disease and Dementia. We will explore the potential impact that training in improvisation can provide for leadership groups, particularly interdisciplinary team members within hospital delivery systems. This workshop will present some of the fundamental premises of improvisation and their relationship to the paradigms of human attachment and neuroscience. We have found that while psychotherapy can help our patients to identify cognitive distortions or psychological defense mechanisms, improvisation can augment this experience by providing a direct experience of collaboration, spontaneity, creative storytelling and the joy of forging a mutual human connection. In addition to reviewing the literature of applied improvisation, we will also present original research from a partnership between University of Michigan and the Detroit Creativity Project, examining the relationship between practicing improvisational theater and mental health among adolescents. Using detailed scales and hundreds of videotaped sessions, presenters will share analyses of hundreds of middle and high school student participants that bear on the question of how improvisation relates to anxiety. The workshop will involve both a didactic presentation followed by a demonstration of some applications of improvisation in which workshop participants will all come together both in group exercises and dyads. The underlying skills presented will include collaboration, spontaneity, and empathy with growing access to the imagination for participants over the course of the workshop. No need for stage-fright – this workshop is tried and tested to provide an energetic and engaging good time for those involved as well as a great learning opportunity – both as a listener and as a participant.

Updates From the Council on Psychiatry and the Law

Chair: Debra A. Pinals, M.D.

Presenters: Peter Ash, M.D., Maya Prabhu, M.D., LL.B., Marvin Stanley Swartz, M.D., Jeffrey Stuart Janofsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of the Council of Psychiatry and the Law and the Committee on Judicial Action for APA; 2) Describe areas of focus of the Council pertinent to practicing psychiatrists;; and 3) Discuss policy implications at the interface of Law and Psychiatry based on topics presented

SUMMARY:

This workshop will provide members with an overview of the process by which the Council on Psychiatry and Law develops APA policy documents, such as Position Statements and Resource Documents. The goal of the workshop is to provide members an update on recent and ongoing issues that the Council is addressing. This workshop will provide the members with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Pinals will provide an overview of the process and discuss a potential position statement on substance use and civil commitment. Dr. Ash will discuss a recent position statement on juvenile solitary confinement. Dr. Prabhu will provide an overview to a resource document to aid psychiatrists who have been targeted by patients engaging in stalking. Dr. Janofsky will describe a position statement written that is designed to address questions about weapons use in clinical settings. Recent legal cases taken up by the Committee on Judicial Action will be reviewed by Dr. Swartz. In each area, the Council will elicit feedback from members regarding the important policy issues. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

Using a Model Curriculum to Promote Lifelong Learning of Evidence-Based Psychopharmacology and Neurobiology

Chair: Matthew Macaluso, D.O.

Presenters: Richard Balon, M.D., Ira David Glick, M.D., Matthew Macaluso, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process for developing a national, peer-reviewed, model curriculum in psychopharmacology and neurobiology utilizing national content experts; 2) Utilize a model curriculum in psychopharmacology for the review and lifelong learning of advanced principles in psychopharmacology including for the ABPN examination or re-certification; and 3) Ensure practicing psychiatrists remain “state of the art” throughout their careers

SUMMARY:

OBJECTIVE: Understand how the model curriculum for teaching psychopharmacology was developed, peer-reviewed, and updated and how it can be utilized by practicing psychiatrists for lifelong learning. **METHODS:** National content experts donated their time and talent to the American Society of Clinical Psychopharmacology to develop a model curriculum in psychopharmacology. The curriculum includes individual slide presentations on the use of psychopharmacology and psychotherapy to treat all mental disorders. The presentations cover the neurobiology of disease, diagnosis, phenomenology, practice guidelines and evidence base regarding treatment modalities. The curriculum has been translated into several languages, is now used worldwide and was developed to optimize learner retention and applicability of the content in clinical practice. **RESULTS:** Residency program directors and other users were surveyed on the curriculum and reported it was user friendly, meaningfully used, and effective at learning core and advanced principles of psychopharmacology. Updates were made to include board-style questions in each presentation. A user guide was added to explain how the curriculum can be operationalized in any residency program. **DISCUSSION/CONCLUSION:** Practicing psychiatrists have less time for lifelong learning and there is wide variation in the practice of psychopharmacology. The model psychopharmacology curriculum helps practicing psychiatrists with the lifelong learning and review of psychopharmacology, including when preparing for the ABPN examination or recertification.

Using CBT for Psychosis in Your Clinical Practice

Chair: David Kingdon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the benefits of exploring the beliefs and perceptions of people who seem intractably psychotic; 2) Understand how psychotic thoughts link to past experiences, current feelings and influence their behavior; 3) Systematically work with voices to understand how they develop and can be managed; 4) Collaboratively analyse fixed beliefs to overcome barriers to social interaction and recovery; and 5) Find alternative methods to protect against anxiety, reduce avoidance and release motivation

SUMMARY:

CBT in psychosis is becoming increasingly available internationally and there are also now a number of effective brief interventions. There is also now research (McCabe et al, 2016) showing that psychiatrists can use these techniques in their clinical practice to improve the therapeutic relationship - which is the best predictor of compliance with treatment generally. In this highly interactive workshop, techniques will be described, demonstrated and discussed and their application to routine clinical practice outlined. Assessment and formulation can be enhanced to form the basis for collaborative understanding of strengths and vulnerabilities, precipitating events and circumstances, which have led to current symptoms. Focused work is then possible, e.g. by brief but effective demystifying of hallucinations, clarifying delusions and thought disorder and combatting negative symptoms. Structured conversational reasoning can assist in reattribution of ‘voices’, development of coping strategies and empowerment in managing critical content. Delusions may benefit from tracing origins of beliefs, reconsidering the context that precipitated them and understanding perpetuating factors, e.g. low self-esteem, isolation and worry, and systematically reorienting the patient towards dealing with these issues. Negative symptoms benefit from attention to avoidance, pacing and timing of activities, recovery goal setting and, paradoxically, reduction in perceived pressure. Research into approaches derived from cognitive therapy for psychosis is flourishing and reference to these will be made. The

focus has narrowed from broad studies demonstrating overall efficacy in schizophrenia to specific areas such as early intervention, in clozapine-resistance, non-adherence and in specific situations where risk, substance misuse, trauma, negative symptoms, paranoia and voices are key issues. This workshop will however primarily focus on development of skills and techniques to use in clinical practice. Further resources – see <http://bit.ly/2NDuAxf>

Violence Motivated by Cultural Identity: How Social Neuroscience Can Contribute to Strategies for Intervention

Chair: Eugenio M. Rothe, M.D.

Presenters: James Lamont Griffith, M.D., Aidaspahic S. Mihajlovic, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1) At the conclusion of this session, the participant will be able to understand the definitions of personal, social and cultural identity.; 2) 2) Will be able to understand the neurobiological basis of inter-group violence motivated by cultural identity; and 3) 3) Will be able to learn two treatment interventions to prevent inter-group violence motivated by cultural identity

SUMMARY:

Identity has been defined as “the organization of self-understandings that define one’s place in the world” and as a synthesis of personal, social, and cultural self-conceptions. It’s divided into: 1) personal identity, 2) social identity, and 3) cultural identity, which refers to the sense of solidarity with the ideas, attitudes, beliefs and behaviors of the members of one’s ethnicity. Social neuroscience can shed new light upon violence motivated by cultural identity, both its causation and potential preventive strategies. Social processes of identity and belonging form culture, but rely upon functional brain circuits of social cognition that shape subjective experience during interactions with other people and the physical world. A neurobiological understanding of social cognition and identity can suggest interventions to prevent inter-group violence when cultural identity motivates aggression towards other cultures. Cultural identity appears closely associated

to operations of the brain’s default mode network (DMN), the brain’s “resting state”, which establishes a set of probabilities for what constitutes a person’s expectable environment and synchronizes other brain systems to be ready to meet expectable demands of the environment. It provides a visceral sense for distinguishing “this is me” and “this is not me.” The DMN calculations for an expectable world extend into extra-personal space as an “Umwelt,” or life-world that can include such identity markers as flags, statues, music, or dress and is experienced as “this is me.” If one of these markers is violated, it is felt personally as if a physical assault upon one’s self. Biologically, identity threats, including Umwelt violations, are coded biologically in the same manner as physical attacks upon one’s body. Two different social cognition systems translate cultural identity into inter-group relations: 1) the categorical social cognition system utilizes simple markers of group membership (skin color, hair texture, language, accent, religious symbols) to determine in-group/out-group status. 2) A slower person-to-person social cognition system enables Mentalization of other persons and empathic responses to their distress. These two social cognition systems reciprocally inhibit each other, such that if one is activated first, it suppresses the other. This social neuroscience perspective suggests two different strategies for countering inter-group violence motivated by cultural identity: 1) Interventions to lower emotional arousal, to diminish ambiguity and uncertainty, and to promote a sense of safety, which in turn activate person-to-person social cognition. 2) Face-to-face interactions that establish empathic bonds between persons also activate person-to-person social cognition and suppress the categorical system. This workshop proposes practical strategies for activating person-to-person social cognition at a societal level.

Walking the Walk: Resident Roadmap to Leadership in Psychiatry

Chair: Adrian Jacques H. Ambrose, M.D.

Presenters: Anees Bahji, M.D., Adjoa Smalls-Mantey, M.D., D.Phil., Michelle Hume, M.D., Ph.D., Pallavi Joshi, D.O., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize opportunities available to residents and fellows for research, community service, and leadership roles in psychiatry.; 2) Identify barriers to developing their professional network.; 3) Review successful strategies and resources that have helped other trainees develop their career and professional identity.; and 4) Identify at least one strategy they plan to implement during their training.

SUMMARY:

As mental health awareness continues to grow, physicians are increasingly choosing Psychiatry as a specialty (5.2% of NRMP positions in 2017). However, trainees often face additional professional struggles after identifying their specialty, including navigating a large professional organization; developing a professional identity; and expanding their network. During medical school and residency, trainees have limited time and resources to identify and optimize the opportunities available to them. As a result, cultivating trainees' leadership skills early in their training will be instrumental in empowering future generations of leaders in psychiatry. This presentation aims to develop strategies for residents and medical students to 1) identify local and national opportunities for leadership experience and career advancement, 2) identify common barriers in leadership through group discussion, and 3) delineate tangible next steps in their own career goals. In this workshop, APA Leadership Fellows will discuss the opportunities available to residents and fellows for research, community service, and leadership roles in psychiatry. The panelists will offer recommendations on developing a strong and unique professional identity deriving both from educational research and from personal experience. Participants will break into small groups to identify barriers to developing their professional identity, networking, or developing their leadership interests. The panelists will review strategies and resources that have been utilized by trainees in past and discuss opportunities available through APA including fellowships, council participation, elected regional and national positions, and mentorship. By the end of this session, participants will be able to identify at least one strategy they can implement during their

training and offer an example of a strategy that they have found to be successful to the workshop group.

Well-Being and Burnout Town Hall 3.0: Well-Being and Diversity

Chair: Richard Fredric Summers, M.D.

Presenters: Saul Levin, M.D., M.P.A., Altha J. Stewart, M.D., Tristan Gorrindo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess your wellbeing and burnout as a psychiatrist; 2) Recognize factors affecting diverse psychiatrists that may impact wellbeing and burnout; 3) Recognize the shared concerns psychiatrists struggle with regarding wellbeing and burnout; and 4) Identify three possible interventions which could improve your wellbeing and decrease burnout

SUMMARY:

Professional burnout and mental health vulnerability are significant concerns affecting physicians-in-training and practicing physicians. Diverse psychiatrists and early career psychiatrists experience unique challenges to and opportunities for wellbeing. Burnout can impact physicians' health and quality of life, the quality of care they provide, and their productivity and workforce participation. There is substantial evidence of burnout and vulnerability among psychiatrists. These issues are important to address efforts to increase diversity and inclusion in the psychiatric workforce, address disparities in care and the wellbeing of mental health care teams. The APA Committee on Psychiatrist Wellbeing and Burnout has focused its work this year on minority psychiatrists and early career psychiatrists. The panelists, who include APA leadership, will lead an open discussion on members' responses to burnout and experience with strategies for promoting wellbeing and combating burnout.

What Does Precision Medicine Promise for Psychiatric Treatment?

Chair: Stephen Michael Stahl, M.D., Ph.D.

Presenters: Hilmiye Nesrin Dilbaz, M.D., Oliver Pogarell, M.D., Nevzat K. Tarhan, M.D., Baris Metin, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Familiarize with the concept of precision medicine (PM) and learn basic components of PM practice; 2) Understand the role of genetic testing and therapeutic drug monitoring in choosing the correct treatment; 3) Appreciate the perspectives of qEEG in terms of contributing to PM and individualizing treatment of neuropsychiatric disorders; 4) Get familiarized with neuromodulation technologies and their interaction with PM practice; and 5) Learn how PM could be used to improve quality of care in addiction treatment

SUMMARY:

Precision medicine (PM) refers to the concept of individualization of treatment according to patient characteristics. In terms of psychiatric practice it encompassed use of genetic testing, therapeutic drug monitoring (TDM) and neuroimaging to understand interindividual variations and enriching treatment options by employing neuromodulation techniques and advances in neurotechnology. Studies showed that genotyping can help psychiatric patients in a number of ways. First, certain variants of receptor genes were found to increase the risk of medication resistance. Second, genotyping the enzymes that metabolize medications can be used to detect reliably individuals that excessively or very slowly metabolize medications. This information is particularly useful for predicting lack of response and toxicity, respectively. Besides genotyping, TDM allows objectively relating improvement or lack of response to plasma levels of medications and thereby helps optimizing the dosage and the decision to stop or continue a specific medication. Quantitative EEG (qEEG) has been investigated in psychiatry for several decades. The method yields quantitatively analyzed parameters of electrophysiological oscillations. qEEG was first studied as a diagnostic tool, however, in recent years a vast amount of studies were published using qEEG to predict treatment response for psychiatric disorders as well. These results suggest that qEEG may effectively contribute to PM. Improvements in signal processing methods and more widespread use of such methods is foreseen in near future. Another important component of PM practice is the use of neurotechnology and neuromodulation.

Neuromodulation treatments include transcranial magnetic stimulation, transcranial direct current stimulation and deep brain stimulation. Recent trials showed that these treatment methods may be efficacious in several disorders that are frequently resistant to medication and associated with high relapse rates such as obsessive compulsive disorder or addiction. Research in addiction particularly suggests that genotyping, neuroimaging, TDM and neuromodulation should be used in an integrative manner to maximize the effectiveness of treatment. Furthermore neurotechnological methods such as virtual reality can also help these patients via simulating environments to be used in psychotherapy. Although deep brain stimulation is already being used for the treatment of incurable psychiatric conditions, nanoneurotechnology assisted new stimulation devices may replace conventional ones in near future. In this symposium we will aim to provide a comprehensive presentation on PM in psychiatry. We will also suggest a research agenda for qEEG, genotyping, TDM and neuromodulation after familiarizing attendees with these methods. A specific focus will be demonstrating how PM can be useful for difficult-to-treat patients such as those suffering from addiction by providing case examples.

What Every Psychiatrist Should Know About HIV

Chair: Lawrence M. McGlynn, M.D.

Presenters: Ripal Shah, M.D., M.P.H., David Tran, M.D., M.P.P., Michael James Polignano, M.D.

Discussant: Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and discuss key aspects of HIV Primary Care including drug-drug interactions and pre-exposure prophylaxis (PrEP); 2) Identify the components of the central nervous system which HIV infects and affects, and their relevance to behavior and change; 3) Understand the cultural aspects of sexuality, and develop a comfortable yet effective script for discussing sex with those at highest risk of acquiring or sharing HIV; and 4) Gain a working knowledge of the effects and challenges of HIV in patients with substance use disorders and create an effective treatment plan

SUMMARY:

According to the Centers for Disease Control, an estimated 1.1 million people in the United States were living with HIV at the end of 2015, the most recent year for which this information is available. Of those people, about 15%, or 1 in 7, did not know they were infected. HIV is largely an urban disease, with most cases occurring in metropolitan areas with 500,000 or more people. The South (including the rural areas), however, has the highest number of people living with HIV. Some populations are at a significantly increased risk of acquiring HIV, and include African-American men who have sex with men, transgender women of color, and those using methamphetamine. At some point in a psychiatrist's career, there is a reasonable likelihood that he, she or they will be asked to provide care for a person living with HIV/AIDS. Most psychiatrists treating patients will see someone at risk for acquiring HIV. HIV is a virus which enters the central nervous system soon after the individual is infected. Even with HIV antiretroviral treatment, changes in cognition, emotion, and/or behavior due to the virus are common. HIV medications and comorbid conditions also contribute to these changes. Psychosocial factors, including rejection and stigma, must also be considered. Understanding the totality of these effects is crucial when providing care to a person living with HIV. In this session, the speakers will provide the attendees with the tools they can use to treat a patient living with HIV/AIDS. A relevant and focused update on what a psychiatrist needs to know about HIV, including an update on antiretroviral medications, comorbidities, and drug-drug interactions will start the session. To provide more relevance to psychiatry, an updated discussion of HIV in the brain will set the stage for a creative interactive application of this knowledge to substance use and sexual behavior in the context of HIV/AIDS, utilizing small groups and problem solving to reinforce learning about effective strategies to work with this population. The speakers in this session include members of the HIV Steering Committee, as well as a Stanford Addiction Medicine Fellow with extensive experience in HIV psychiatry. The presenters will be honored to have Marshall Forstein as the session's discussant.

Will My Patient Be the Next Mass Shooter?**Mastering Risk Assessment and Minimizing Liability**

Chair: Adrienne M. Saxton, M.D.

Presenters: Sara G. West, M.D., Philip A. Saragoza, M.D., Ashley VanDercar, M.D., J.D., Stephen G. Noffsinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use a systematized approach to assess violence risk; 2) Determine appropriate interventions for various levels of risk; 3) Understand the basics of malpractice liability for patients' violent acts; and 4) Implement practical tips to reduce risk of liability for patient violence

SUMMARY:

In an era where headlines about mass shootings and other forms of gun violence seem to be never ending, public fear is on the rise. Increasingly, psychiatrists are being asked to assess whether individuals who have exhibited strange behavior or made threats are safe to remain at work or school, or to return following a leave of absence. Although psychiatrists may rarely think of themselves as making "life or death" decisions, conducting a violence risk assessment and deciding what intervention is necessary comes with great responsibility. This task can be anxiety provoking for psychiatrists who worry about making the "wrong call." In addition to concern about the potential loss of life that could result from releasing a patient who goes on to commit a serious violent act, many psychiatrists also worry about being sued. This session will aim to provide general psychiatrists a practical overview of violence risk assessment. We will discuss the basics of malpractice liability due to patient violence, review clinical scenarios with potential for liability (even in the absence of overt threats), and offer practical tips to reduce liability risk. Case scenarios drawn from actual events will be used to illustrate concepts and allow psychiatrists to apply their new skills.

Workplace Mental Health: Optimizing Outcomes

Chair: Michelle B. Riba, M.D., M.S.

Presenters: Sagar V. Parikh, M.D., Raymond W. Lam, M.D., Christine Moutier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To review scope of the problem; 2) To present data on the human costs and financial costs of unhealthy minds at work; 3) To highlight workplace suicides; 4) To review some specific barriers related to neurocognitive assessments and impairments; and 5) To discuss depression and bipolar disorders and some specific models and tools that can be useful by mental health clinicians

SUMMARY:

The consequences of depression, anxiety, substance abuse and other mental health conditions in the workplace are enormous and are directly linked with higher rates of absenteeism and presenteeism; costly staff turnover; lost productivity; and higher medical costs. The World Health Organization data confirms that clinical depression is the leading cause of disability worldwide with an enormous global economic impact. There are a number of traditional barriers to effective programs including stigma and distrust, absence of or lack of information regarding programs, access issues, lack of training of employees and supervisors, absence of vocal leadership, etc. These issues are global and affect large and small companies and employers. This workshop will present key topics on prevention, evaluation and management of mental health problems in the workplace and will present tools for participants to become knowledgeable and for engagement in improving workplace mental health. The presenters will highlight technology that might be helpful; ways of collaborating with various groups within corporations such as employee assistance programs and human resources ; educational models that might be useful to explore; how to assess what might be needed and best ways to deliver services; and the challenges and strategies of this type of collaboration. Resources will be provided to participants and opportunities for questions and answers will be provided.

WPA Initiatives: An Update

Chairs: Helen E. Herrman, M.D., M.B.B.S., Saul Levin, M.D., M.P.A.

Presenters: Roger Man Kin Ng, M.D., Thomas G. Schulze, Michel Botbol

Discussant: Afzal Javed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Sharing WPA's initiatives in global psychiatry; 2) Discussions about current directions for global psychiatry; and 3) Developing partnership with other professional organisations

SUMMARY:

Mental disorders are highly prevalent and cause considerable suffering and disease burden all over the world. The public health impact of mental disorders is profound as the estimated disability-adjusted life-years attributable to mental disorders have been shown to be very high. Despite the growing evidence about the impact of mental illnesses, mental health services continue showing big gaps. With less number of mental health professionals, scarcity of mental health resources & now often facing additional problems of migration of trained psychiatrists and mental health professionals to the already resource rich countries, the situation gets even worse. There are also concerns among the professionals that profession is in crisis and that it faces a number of external and internal challenges. Issues regarding diagnosis, treatment, prognosis and outcome of mental health disorders along with demedicalization of healthcare within mental health services & marginalisation of psychiatrists in service development and organisation are posing questions whether psychiatrists are endangered species. This Forum will discuss an overview about such challenges with discussions on WPA's contribution in different fields of mental health..

Writing and Getting Published: Developing This Important Skill Set for Psychiatrists

Chair: Rajesh R. Tampi, M.D., M.S.

Presenters: Juan Joseph Young, M.D., Meera Balasubramaniam, M.B.B.S., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To discuss the importance of developing writing and publishing skills among psychiatrists; 2) To describe the various steps that are needed to develop different types of manuscripts; 3) To elucidate the ways of effectively

searching various large academic databases; 4) To enumerate effective ways of replying to reviewer's comments to ensure acceptance of manuscript for publication; and 5) To elaborate on the process of publishing book chapters and books

SUMMARY:

Programs that train professional in psychiatry expect the trainees to engage in scholarly activities including writing scientific manuscripts and getting them published either in books or journals. However, the training provided to achieve and or maintain academic and scholarly productivity is limited. Additionally, there is no standard format or curriculum to teach the trainees on how to acquire their own skill set to develop and implement their own academic portfolio. Furthermore, these deficiencies in developing scholarly productivity continue hinder the career growth of the professional caring for individuals with psychiatric disorders. The clinical and administrative work load for these professionals often presents additional challenge that prevents them from acquiring the skill set to develop a writing and publishing career. In this workshop, we will discuss ideas and methods on how a psychiatrist can develop and implement their own scientific writing and publishing career. We will provide step by step instructions on how scientific manuscripts can be developed and published. Additionally, the faculty presenting at this workshop will provide case examples from their academic portfolio to illustrate how specific manuscripts were developed and published.

Tuesday, May 21, 2019

A History of Protests at the APA: Dissent, Progress, and Accountability Within Psychiatry

Chair: Daniel Fisher

Presenters: Xinlin Chen, M.D., Tamar Debora Lavy, M.D., Jessica Elizabeth Isom, M.D., M.P.H., Swapnil Gupta, M.D., M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the historical contributions of patient rights and advocacy groups to medicine and psychiatry; 2) Describe the history of the APA Annual Meeting protests from the 1970s

to present; 3) Illustrate an awareness of alternative explanatory models of mental health in addition to the biomedical approach; 4) Recognize power inequalities within the patient-psychiatrist relationship as intersecting with other systems of oppression such as racism, homophobia, transphobia, classism, sexism, ableism, etc.; and 5) Gain increased comfort in having a dialogue with members of APA protests

SUMMARY:

During the 2018 APA Annual Meeting in New York City, registered attendees were advised to avoid displaying a conference badge or tote bag outside of the meeting building where a group of demonstrators had convened. The alert was referring to a collection of a few dozen people stationed across the street from the Javits Center. Representatives of various community activist groups, patient advocacy organizations, individuals from the community, and mental health service providers and practicing psychiatrists were involved. The non-violent protest titled "First Do No Harm" featured a series of speeches, poetry readings, music, and stories exploring people's lived experiences within the psychiatric system. Aside from those participating in the protest, only a few APA attendee psychiatrists interacted with the group, though some people attended the Radical Caucus of the APA which was held at the same time. This workshop will provide an introduction to the history of protests and actions held at the APA Annual Meetings, from San Francisco in 1971 to the present day. We aim to provide a historical overview of these groups presence and their impact. In so doing we will recognize the diverse set of perspectives, which have, for example, included those with lived experience of mental illness offering alternative explanatory models and mental health professionals offering critique and reflections on their careers and research. Illustrating the importance of achieving success through collaboration, the workshop will also include facilitated small group discussions focused on revealing divergent opinions in an effort to contribute added value to our collective work and experience. We welcome active participation from the audience through a variety of additional modalities including Q&A, and through multimedia

such as videos, music, and poetry. By borrowing from narrative medicine and psychoanalytic frameworks for understanding dissent and justice, the presenters will also offer reflections on our professional identities as they relate to change, knowledge, power dynamics including the concept of “self and other.” The space we create without our badges or tote bags will encourage an open conversation about who are we as psychiatrists, as patients, and as people. Please join us as we reflect on almost 50 years of protests at the APA and honor those who have contributed to the resulting progress and accountability.

A Patient-Centered Approach to School Refusal: A Day Program’s Guide to Tackling One of Child and Adolescent Psychiatry’s Most Difficult Problems

Chair: Brandon Johnson, M.D.

Presenter: Shilpa R. Taufique, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of school refusal on individuals, communities, and the educational system at large; 2) Identify the complex range of factors that contribute to school refusal behavior; 3) Demonstrate knowledge of how to comprehensively assess patients with school refusal; and 4) Understand how to develop and implement a comprehensive and patient centered treatment plan to target school refusal

SUMMARY:

School refusal is one descriptor of a complex set of behaviors that result in children and adolescents not attending school regularly. However, a wide array of terms exists to describe students who do not regularly attend school. This heterogeneity of terminology stems from the vast array of presentations that result in similar outcomes. Terms like “truancy” and “school avoidance” attempt to highlight underlying causes, but the phenomenon is often multifactorial and complex. School refusal is significantly detrimental to the individual student, the school, and the community at large. It contributes to school drop-out rates, future unemployment, and lower economic potential. School refusal is often indicative of significant psychiatric pathology and lack of adequate

psychosocial supports. Furthermore, school refusal puts marginalized and vulnerable populations at further risk when not adequately addressed. Families, schools, and health providers should view school refusal as an urgent problem in need of comprehensive assessment and intervention. Appropriate evaluation of school refusal must elucidate a wide range of contributing factors, including: psychiatric symptoms, family stressors, cultural factors, cognitive and learning deficits, appropriateness of school fit, and safety factors. When all of the contributing factors are determined, a comprehensive treatment plan is essential to re-engage the student in the appropriate academic setting. Collaboration among the student, family, school, health providers, and other support systems leads to better outcomes for these youth. This presentation will discuss the multiple factors that contribute to school refusal and describe the components of a comprehensive assessment of students with school refusal behavior. A comprehensive and collaborative approach to youth with school refusal will be highlighted through the use of case material and treatment plans from the Comprehensive Adolescent Education and Rehabilitation Service (CARES) program. CARES is an adolescent intensive outpatient program that treats high risk teenagers with mental health and substance use diagnoses. The program is co-located with a New York City public high school, where educational and clinical services work hand-in-hand. A majority of the students at CARES present with a history of significant school refusal behaviors – some students having missed several months, or even years, of school. The individualized and comprehensive treatment plans utilized at CARES address the complex etiology of school refusal behaviors, leading to a high success rate in a population that are otherwise unlikely to graduate. Presenters will share case presentations from CARES, describe how comprehensive treatment plans were developed for these cases, and describe the outcomes of the interventions as they relate to school refusal and overall patient functioning.

A Resident’s Guide to Borderline Personality Disorder—From the Experts (Part I of II)

Chair: Brian A. Palmer, M.D., M.P.H.

Presenters: Lois W. Choi-Kain, M.D., Perry Hoffman, Ph.D., Robin Kissell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the BPD diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); 2) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability; 3) Articulate principles of effective psychopharmacology for BPD, including both medication choices and the process of discussing medications with a patient; and 4) Know when to prioritize BPD's treatment and when to defer until a comorbid disorder is resolved

SUMMARY:

This is a repeat submission of a general session in 2 parts that has been extremely well attended and presented at each of the last 8 APA annual meetings. Either part of this two-part workshop could be attended independently; back to back scheduling will allow for both to be attended sequentially. Borderline Personality Disorder (BPD) is a common and serious psychiatric illness, impacting 2-3% of the population and 15-20% of psychiatric clinical samples. Psychiatric residents encounter patients with BPD early and frequently in their training, across emergency, hospital, and resident clinic settings. Particularly in light of the intense interpersonal nature of BPD symptoms, residents often feel ill-equipped to provide effective care to this patient group. This workshop begins with information about the disorder, its course and outcome, and its genetics and comorbidities that can be used to anchor treatment in expected improvement. Building on this, principles of effective treatment are shared in a way that residents can begin to recognize when they are helping – and when they may be harming – the patient's progress. The workshop then moves into the experiences common to residents and how these can be understood in a context of treatment, with specific approaches helpful in brief interventions. Principles around safety management in these acute settings will help residents feel more confident – and competent – in both assessing and intervening to address suicidal thoughts in BPD patients. The

second part of the workshop begins with a review of the principles from part one and then uses video examples to introduced the painful and difficult experience of families and how they can be supported and learn skillful ways of interacting with their BPD loved ones. Specific principles for emergency and hospital settings are then shared in a way that should prove quite practical for trainees, followed by evidence-based pharmacological management principles. Ample time for questions and case discussions is included throughout the workshop.

A Resident's Guide to Borderline Personality Disorder—From the Experts (Part II of II)

Chair: Brian A. Palmer, M.D., M.P.H.

Presenters: Lois W. Choi-Kain, M.D., Perry Hoffman, Ph.D., Robin Kissell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the BPD diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); 2) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability; 3) Articulate principles of effective psychopharmacology for BPD, including both medication choices and the process of discussing medications with a patient; and 4) Know when to prioritize BPD's treatment and when to defer until a comorbid disorder is resolved

SUMMARY:

This is a repeat submission of a general session in 2 parts that has been extremely well attended and presented at each of the last 8 APA annual meetings. Either part of this two-part workshop could be attended independently; back to back scheduling will allow for both to be attended sequentially. Borderline Personality Disorder (BPD) is a common and serious psychiatric illness, impacting 2-3% of the population and 15-20% of psychiatric clinical samples. Psychiatric residents encounter patients with BPD early and frequently in their training, across emergency, hospital, and resident clinic settings. Particularly in light of the intense interpersonal nature of BPD symptoms, residents often feel ill-equipped to provide effective care to

this patient group. This workshop begins with information about the disorder, its course and outcome, and its genetics and comorbidities that can be used to anchor treatment in expected improvement. Building on this, principles of effective treatment are shared in a way that residents can begin to recognize when they are helping – and when they may be harming – the patient’s progress. The workshop then moves into the experiences common to residents and how these can be understood in a context of treatment, with specific approaches helpful in brief interventions. Principles around safety management in these acute settings will help residents feel more confident – and competent – in both assessing and intervening to address suicidal thoughts in BPD patients. The second part of the workshop begins with a review of the principles from part one and then uses video examples to introduced the painful and difficult experience of families and how they can be supported and learn skillful ways of interacting with their BPD loved ones. Specific principles for emergency and hospital settings are then shared in a way that should prove quite practical for trainees, followed by evidence-based pharmacological management principles. Ample time for questions and case discussions is included throughout the workshop.

A Systematic Approach to Developing Mental Health Programs for the Workplace

Chair: Jon Wesley Boyd, M.D., Ph.D.

Presenter: Christopher Taekyu Lim, M.D.

Discussants: Steven M. Kleiner, M.D., John M. Santopietro, M.D., Hyong Un, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply a comprehensive framework to assessing the systems and initiatives in place to support mental health within a given workplace; 2) Identify strengths and gaps in the mental health programs within their own workplaces; 3) Provide examples of innovative interventions to support workplace mental health; and 4) Predict implementation challenges and propose metrics to assess workplace mental health program effectiveness

SUMMARY:

American employers large and small are increasingly taking interest in supporting mental health in the workplace. The reasons are manifold; among the most prominent are to optimize productivity, to support talent recruitment and retention, and to control the overall costs of healthcare benefits. In particular, within the medical setting, physician burnout and suicide have received substantial attention. While employers across industries have given affirmation of the importance of mental health, there have been limited accounts to date of employers implementing novel programs to support mental health in the workplace. This session serves to teach participants an approach to developing a comprehensive program for workplace mental health. The approach has three components: supporting mental health maintenance, treating mental illness, and eliminating internal barriers to accessing resources. One focus of the session will be to explore what principles apply across medical and non-medical workplaces and, by contrast, what the unique features and challenges are within specific workplace settings. The session will begin with a live survey in which participants will provide responses about the mental health resources available to staff and the culture around staff mental health at their own workplaces. Then, we will discuss the responses against our three-part framework for workplace mental health. Our diverse panel of experts, which includes extensive collective experience across both medical and non-medical workplace settings, will discuss the results and present examples of effective, comprehensive mental health programs from workplaces they have observed. As part of the discussion, our panel will provide advice on the implementation, monitoring, and continuous improvement of these programs. Finally, we will open the session for a Q&A with our panel.

Access, Privacy, and Utility of Historical Psychiatric Records: Central Lunatic Asylum for Colored Insane

Chair: Eric R. Williams, M.D.

Presenter: King E. Davis, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Critical knowledge of how public psychiatric records are maintained by states

and agencies; 2) Be critically familiar with the various state laws on retention of psychiatric records and the absence of a singular national law; 3) Distinguish between the expectations of families, scholars, and media for access and utilization of historical psychiatric records; 4) Understand the processes used in the archives project to protect and balance increased access, privacy, and utility; and 5) Develop a critical interest in the historical records in each state that documents care of blacks with diagnosed mental illness

SUMMARY:

The primary intent of the lecture is to explore the dilemma that surrounds increasing access by families, scholars, and media to historic psychiatric records. Each state has responsibility for crafting laws and policies that govern retention of documents and specific restrictions that determine who has access to records and documents including information on the diagnosis and treatment of mental illness. These state requirements will be compared and contrasted with federal laws designed to insure that various classes of health information remain protected from disclosure. The lecture will use the Central Lunatic Asylum for Colored Insane Archives as the evidentiary base for examining questions about how to balance increased access by families, scholars, and media while adhering to privacy concerns in HIPAA, IRBs, and professional ethics. Project goals, findings, hypotheses, processes, collaborations, funding, and technological methods used to support access to the archives will be shared along with continued barriers and impediments to the records. A detailed examination of the risks involved in increasing access in a digital environment where intrusions in large data bases will be included. The presenter will offer a draft national policy and activities for the APA for resolving the future dilemmas involved in increasing access while using technology to retain legally required privacy.

Achieving Inclusive Excellence Through Cultural Competence

Chair: Ranna Parekh, M.D.

Presenters: Leon McDougle, Monica Basco, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify concrete actions for senior leadership that are essential to assure that diversity and inclusion become part of the culture of any organization.; 2) Discover strategies to reframe diversity and inclusion from a problem to a competitive advantage for organizations..; 3) Gain an understanding of how cultural competency training can improve the management of staff and services for clients and patients from various sociodemographic and cultural backgrounds.; and 4) Recognize how career and leadership development programs that recruit diverse participants can help fill talent pools, but pathways to employment and advancement must be created that address commo

SUMMARY:

Driven by the under-representation of women and people of color in science, technology, engineering, and math (STEM), strategies for achieving greater diversity and inclusion have been hotly debated over the last few decades. Educationally, the number of women and people of color who have completed college and advancement in STEM fields have increased, but this improvement is not well-reflected in employment or advancement in STEM fields.¹⁻⁶ Some limited gains have been made such as women and racial/ ethnic minorities in C-Suite positions, university leadership, and on boards of directors, but overall the numbers do not match stated level of interest in driving excellence and innovation through greater diversity and inclusion.⁷⁻⁸ Diversity programs exist in all labor sectors; they have evolved organically, are tailored to the unique needs of an organization, and have their own benchmarks for success. To identify the most promising practices for creating an environment of inclusive excellence, experts from government, industry, medicine, academia, and advocacy convened to share their experience and expertise in the hopes of identifying key challenges, strategies, and meaningful metrics for diversity and inclusion across sectors. Stimulated by initial work on this topic by the White House Office of Science and Technology Policy during the last administration, convenings were organized in 2016 and 2017 by the American Psychiatric Association, General Motors, and The Ohio State University Wexner Medical Center. Workshop participants represented small and large businesses,

various academic institutions and government agencies, professionals across scientific and technical fields, and advocates in support of a range of under-represented groups.

Actions Speak Louder Than Words: Understanding What Can't Be Verbalized in Patients With Intellectual Disability and Traumatic Brain Injury

Chair: Julie P. Gentile, M.D.

Presenters: Nita V. Bhatt, M.D., M.P.H., Kimberly Stubbs, M.D., Brandon Withers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn effective techniques for interviewing patients with limited expressive language skills, traumatic brain injury, and intellectual disability; 2) Using strawpolling and active audience participation, practice identifying and treating mental illness in patients with cognitive deficits; 3) Identify non-verbal communication styles from various cultural and ethnic origins; 4) Facilitate group discussion regarding the challenges in the diagnostic assessment of psychiatric disorders in individuals with intellectual disability and traumatic brain injuries; and 5) Assess the level of collaboration and use of nonverbal communication between therapist and patient via the use of clinical vignette and video presentations

SUMMARY:

Interviewing patients with Intellectual disability (ID) can be challenging due to patient factors such as limited communication abilities and difficulty sustaining attention. Physician related factors that may pose a challenge include limited experience treating patients with ID resulting in a lack of confidence. Recognizing these factors and gaining experience treating these individuals are the best ways to overcome these challenges. When evaluating an individual with ID, it is essential to gather collateral information. If the patient gives consent, it is helpful to have a collateral data source or other invested party present for the interview, as they are able to provide valuable, objective information. The use of collateral sources; however, should not be used in lieu of direct communication with the identified patient. It is important to speak directly to the patient during the interview, even if

they are nonverbal or if you are obtaining information from a third party during the interview. According to compiled fact sheets produced by the National Institute on Deafness and Other Communication Disorders (NIDCD), between 6 and 8 million people in the United States have some form of communication impairment. Being aware of unspoken subtleties during an encounter can offer valuable information that a patient may be unwilling or unable to put into words. During our session, we will use interactive audiovisual aids to facilitate group discussion on how to evaluate the non-verbal patient across all patient populations including patients with intellectual disabilities and traumatic brain injuries. The facilitators will provide examples of nonverbal behaviors as diagnostic criteria for common psychiatric disorders. Consideration will be given for cultural influences and variations in nonverbal communication that will improve the physician's understanding of a diverse patient population. Significant information is often revealed through paralanguage which requires attention to emotional and facial expressions that have universal meaning. Clinical vignettes and video recordings will be referenced with special attention given to universal facial expressions of emotion. The information gathered from this intentional task can be used to guide treatment in a manner that is tolerable and therapeutic for the patient. Similarly, the psychiatrist's nonverbal behaviors also greatly impact the establishment of rapport and the maintenance of a strong therapeutic alliance. At the conclusion of our session the learner will be able to assess patients' communications skills in a non-threatening manner with consideration of his/her own coordination and navigate diagnostic challenges in a diverse patient population.

Adapting Cognitive Behavior Therapy for Older Adults

Chairs: David Allan Casey, M.D., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will learn how to establish a collaborative therapeutic relationship with elderly patients in CBT; 2) The participant will learn how to adapt and modify tools of CBT for older

patients, particularly behavioral activation; and 3) The participant will observe how to address realistic loss, grief, and physical illness in CBT

SUMMARY:

In this session, the focus will be on adaptations of CBT designed to optimize this treatment for elderly patients. Such modifications are especially relevant for very elderly, frail, or psychomotor retarded patients. Some key factors include establishing a collaborative therapeutic relationship with a demoralized patient who may not be psychologically minded or aware of psychotherapy, setting realistic goals for each session as well as the overall treatment, and keeping the session agenda brief. Common issues include dealing with realistic loss, grief, pain, limitations or disability. Behavioral activation is often the key element of treatment, and the most useful cognitive interventions flow from review and discussion of the difficulties encountered in carrying out a behavioral activation plan. Rather than "off the shelf" tools, the therapist must often craft a homework tool (such as an activity schedule) devised to meet the individual patient's unique needs. The inclusion of family members and caregivers is a frequent element in this type of therapy. Even more than the typical course of CBT, the focus is on improving quality of life and marshaling the patient's lifelong coping skills to meet the present challenge, rather than cure. The frame must be flexible enough to allow for ventilation, life-review, and considerable existential work, so that an element of supportive therapy is seamlessly woven into the CBT model. The therapist's tone is typically conversational and informal. Discussion of the patient's belief systems about aging, death, and their place in their family and community is often a part of this "supportive CBT". Demoralized, depressed elders may doubt their continued usefulness, and deal with significant, complex fears about loneliness, control, finances, becoming a burden, and dependency. All these issues are fair game in this model. Depression, anxiety, aging, cognitive loss, and physical illness present as a tapestry rather than discrete symptoms, and a coping model is useful in addressing these issues. The presenters have decades of experience in this field and presented widely at the APA and elsewhere on CBT and aging topics. The presentation will include a brief didactic

followed by role-play of a case, with extensive audience participation.

Adapting Treatment Approaches for Borderline Personality Disorder to Narcissistic Personality Disorder: Is It Good Enough?

*Chairs: Lois W. Choi-Kain, M.D., Kim Woynowski
Presenters: Adam Jaroszewski, Erik Nook*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the diagnosis of narcissistic personality disorder, its features, course, and clinical features.; 2) Describe a network analysis approach to understanding the symptoms of narcissistic personality disorder.; and 3) Propose adaptations of cognitive behavioral therapy, dialectical behavioral therapy, general psychiatric management, and mentalization based treatment approaches to narcissistic personality disorder

SUMMARY:

While prevalent and complicating of psychiatric treatment, narcissistic personality disorder (NPD) is much less well understood than borderline personality disorder (BPD). No evidence based treatments have been validated to date for its treatment. This general session will review the NPD diagnosis, its epidemiology, course, and clinical features and propose modification of common evidence based approaches for borderline personality disorder (BPD) for its treatment. First, to provide a coherent model of NPD as a syndrome, we will present a network analysis conceptualization of the disorder, as a causal systems of interacting symptoms. Viewing NPD through this lens may help clinicians and researchers elucidate this disorder's complex symptom structure and identify core symptoms ripe for clinical intervention. We will also explain key principles and evidence for the network model of psychopathology. Then, we will describe the theoretical structure of the NPD network, highlighting core symptoms as accessible targets for psychotherapy. In addition, we will present adaptations of both the clinical formulation and core treatment strategies from general psychiatric management, cognitive behavioral therapy, dialectical behavioral therapy, and mentalization based treatment approaches to NPD. Overall, this

session aims to equip participants with skills to i) formulate narcissistic dysfunction as a product of self-esteem dysregulation, maladaptive beliefs and behaviors, and instabilities in attachment functioning as well as reflective processes; and ii) use clinical and psychotherapeutic interventions to organize the treatment process that allows clinician to develop a working alliance with the patient to reduce their narcissistic dysfunction, enhance their realistic self-assessment, and enrich their interpersonal interactions.

Add “Pop” to Your Presentations! Innovative Use of Video Clips to Revitalize Your Lecture

Chair: Robert N. Averbuch, M.D.

Presenters: Maanasi H. Chandarana, D.O., Ana T. Turner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the advantages of adding video clips to a presentation; 2) Describe the steps needed to “capture” a video clip from live television or a DVR; 3) Apply current copyright and fair use law to multimedia presentations; 4) List the steps required to capture video from a streaming digital source; and 5) Describe some potential pitfalls of using video to illustrate psychopathology

SUMMARY:

Popular media, born out of “pop” culture, is replete with examples of mental illness and its treatment. Though some portrayals are exaggerated and reinforce stereotypes, many are surprisingly accurate, informative, and entertaining. Adding illustrative clips from television and movies can revitalize almost any slide-based presentation and better engage the audience. And with the explosion of content available on the internet, it would seem to be easier than ever to incorporate video into presentations. Yet, all too often, a lack of technical “knowhow” and fears of copyright infringement limit application of this valuable medium. This session is an outgrowth of a prior APA offering, “Teaching with Digital Video” and will review many of the basics discussed in that workshop, including very practical step-by-step instruction on how to procure video clips from a variety of sources. Going beyond the basics we will explore the use of a wider variety of

video resources, with particular focus on streaming digital media such as Netflix, Amazon Prime, YouTube, etc. Of particular relevance, we include a discussion of applicable copyright law and fair use in the realm of digital media. In this highly interactive session, participants will be asked to critique a wide range of video clips from popular culture/media. Psychiatric educators will provide examples from television, film, and the internet that have been utilized in their teaching and will describe how they helped to revitalize previously “dry” material. Additionally, we will explore how participants can begin to use this valuable tool of pedagogy in their own presentations.

Addictive Substances and Sleep: How Alcohol, Opioids, and Cannabis Impact Sleep

Chair: Bhanu Prakash Kolla, M.D.

Presenters: John Michael Bostwick, M.D., Meghna Mansukhani, Subhajit Chakravorty

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of alcohol use on sleep disordered breathing, insomnia/apnea and other sleep disorders; 2) Recognize sleep disorders in patients who are using prescription and illicit opioids; 3) Understand the influence of cannabis on sleep disordered breathing, and sleep disruption and daytime sleepiness; 4) Recognize how sleep disorders can increase the risk of substance use and relapse; and 5) Identify how to Provide manage care for patients with comorbid substance use and addicted populations with sleep disorders

SUMMARY:

The use of alcohol in the general population as well as the prevalence of alcohol use disorders are increasing. A significant proportion of the population is using prescription opioids and the rates of opioid use disorders are also on the rise. With legalization, the number of people who use cannabis is also growing/increasing. Additionally, some states in the US have recently legalized the use of medical marijuana for the treatment of sleep apnea. Sleep-related complaints are disruption is extremely common in patients who use these addictive substances. These substances can also also impact

sleep-related breathing parameters during sleep. Furthermore, sleep disruption seen in the context of substance use may continue into early abstinence and increase risk of relapse. In this session, three addiction psychiatrists, two of whom have subspecialty training in Sleep Medicine and another Sleep Medicine provider will discuss the interplay between sleep disorders and substance use. During this session, attendees will learn about the mechanisms whereby by which alcohol, opioids and other commonly misused substances can affect sleep. Specifically, the impact of alcohol, opioids and cannabis on normal sleep, sleep apnea, restless leg syndrome, periodic limb movements, insomnia and hypersomnia will be discussed. . Also, some states have recently legalized the use of medical marijuana for the treatment of sleep apnea. We will review specifically examined discuss the literature examining the impact of marijuana on sleep apnea and discuss outline current controversies in this area. We will also include a discussion on how to approach the diagnosis and management of patients with substance use disorders and sleep-related complaints problems. This session will include include 4 short lectures followed by case- based discussion and audience responses. The session aims to provide clinicians with an opportunity to familiarize themselves with the latest data examining the impact of alcohol, opioids and cannabis on normal sleep and common sleep disorders. At the end of the session, attendees providers will be able to understand the nature and degree of comorbidity between substance use and sleep disorders, recognize common sleep disorders encountered during the period of substance use and recovery as well as and appropriately counsel and manage patients with substance use disorders who have report sleep-related complaints.

Adding Flexibility to Your Practice? It's Not a Stretch! Understanding Yoga for Depression

Chair: Meera Menon, M.D.

Presenters: Amit A. Parikh, M.D., Amy B. Mattern, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the history of yoga

practice around the world as well as its rise to popularity in recent years.; 2) Explain the role of yoga in the treatment of depression.; 3) Summarize the evidence to support use of yoga as a treatment modality for depression.; 4) Demonstrate examples of yoga techniques with the help of a certified yoga instructor.; and 5) Develop ways to incorporate yoga techniques into clinical practice.

SUMMARY:

Yoga is a form of complementary medicine that has played a large role in medical treatment in the East for thousands of years. As the use of complementary and alternative medicine has recently expanded in the United States, so has the practice of yoga. According to the Adult Alternative Medicine (ALT) supplement to the National Health Interview Survey (NHIS), the percentage of adults practicing yoga nearly doubled between the years 2002 and 2012, from 5.1% to 9.5% (1). As yoga practice comes to the forefront, more studies are identifying a role of yoga in treating disorders exacerbated by stress (2). For example, benefit is noted in the treatment of cardiovascular disorders, chronic low back pain, breast cancer, hypertension, irritable bowel syndrome, and fibromyalgia (2). Yoga can also be beneficial in reducing symptoms of depression. In one study of individuals with major depressive disorder, the Beck Depression Inventory II (BDI-II) scores of subjects decreased from 24.6 to 6.0 after a twelve-week course of frequent Iyengar yoga practice (3). This impressive reduction in symptomatology is attributed to various neurologic processes. Some studies identify yoga as causing increased peripheral nervous system activity (3,4). Streeter et al posit that regular yoga practice can lead to increased thalamic GABA levels (5). In yet another study, the impacts of yoga and exercise were differentiated. High-intensity exercise was more associated with increased cortisol levels and activation of the sympathetic nervous system (6). Yoga or low-intensity exercise was noted to have lowered plasma epinephrine and norepinephrine (6). While the practice of yoga has shown great benefits, there are also downfalls. Financial constraints can serve as a barrier to practicing yoga, as the price of a class averages \$20.00 nationally. When done incorrectly, certain yoga postures can contribute to severe physical injury that is thought to be

comparable to other forms of exercise. The session will begin and end with a yoga practice that will be optional to session attendees. Those who wish to participate will find the practice to be easy to perform and one that they can incorporate in treatment with their own patients. The speakers of this presentation all have a regular yoga practice, and one has completed a 200 hour yoga teacher training certification through the Yoga Alliance

Addressing Mass Violence in America: Causes, Impacts, and Solutions

Chair: Joseph John Parks, M.D.

Presenters: John S. Rozel, M.D., Frank Eugene Shelp, M.D., Sara Coffey, D.O., Jason Beaman, M.D., D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe trends in the incidence of mass violence over time in comparison to other types of violence; 2) Describe the incidence of mental illness and addiction disorders diagnosis or symptoms in perpetrators of mass shootings and other common characteristics of mass shooters; 3) Explain the limits of the ability of mental health clinicians to predict which individuals will perpetrate mass shootings; 4) Implement recommendations for mental health clinicians and services on how to reduce the risk and incidence of future violence.; and 5) Make recommendations to key decision makers including leaders of healthcare organizations, State and Federal officials, and professional organizations.

SUMMARY:

The United States has had more mass shootings, often defined as crimes in which four or more people are shot in an event (or related series of events), than any other country in the world. The overwhelming majority of perpetrators are white American males, who act alone, and ultimately either commit suicide or killed by law enforcement officers or civilians at the scene of the attack. In some instances the perpetrators are captured alive and subsequently tried and incarcerated or institutionalized depending on the legal verdict. Studies indicate that the rate at which public mass shootings occur has tripled since 2011. Between 1982 and 2011, a mass shooting occurred roughly

once every 200 days. However, between 2011 and 2014 that rate has accelerated greatly with at least one mass shooting occurring every 64 days. The major themes in public discourse in response to both the increased incidence in the increased Press coverage of mass shootings are that: Mental illness is the cause of mass violence, persons with mental illness should be restricted from purchasing firearms, psychiatric diagnosis can predict such crimes before they happen, and convey the general message that people should fear mentally ill persons, particularly when they are loners or homeless. A growing body of research suggests that perpetrators of mass violence fall into three categories (with considerable overlap): 1) persons with mental illness; 2) ideological zealots (including terrorists); 3) disaffected persons who are alienated from society or disgruntled employees. In the former, the vast majority are persons who are not receiving treatment for their mental illness. Research has identified many individual risk factors for violence. While these can identify persons with greatest risk for violence, they are unable to predict when this risk is imminent. Moreover, this body of knowledge has not been translated into instruments or protocols for evaluating people for their violence potential. The same applies to persons with mental illness. There are identified risk factors for violence but no methodology for how these can be applied for clinical use and predictive – preventive purposes. Thus, while clinicians might be able to tell us who is at risk for violence, they can't tell you when this risk is imminent. There is increasing demand for steps to be taken to identify perpetrators of violence and develop preventive measures, but no serious effort to understand the problem or increased resources for assessment and treatment. The National Council Medical Directors Institute (MDI) convened an expert panel to conduct an analysis of the root causes, contributing factors, characteristics of perpetrators, impacts on victims and society and propose actionable solutions that will be described in this presentation on Mass Violence in America.

Addressing the Multiplicative Effects of Immigration on Psychiatric Training, Practice, and Care

Chair: Bernardo Ng, M.D.

Presenters: Jennifer Severe, M.D., Nichole I. Goodsmith, M.D., Ph.D., Josepha A. Immanuel, M.D. Discussant: Michelle B. Riba, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify ways in which immigration-related issues may negatively impact the health of psychiatry providers, trainees and patients.; 2) Describe issues that training directors should consider addressing with psychiatric residents regarding immigration and how to optimize well-being.; 3) Learn psychiatrists' attitudes towards talking about immigration status with their patients; 4) List the potential benefits and challenges of talking about immigration with patients in our practice.; and 5) Address the intersection of parental' immigration status and children's mental health.

SUMMARY:

Addressing the Multiplicative effects of Immigration on Psychiatric Training, Practice and Care With the growing number of immigrants in the United States, immigration has become an increasingly complex, sensitive and stressful topic with downstream effects on social, political, medical and psychiatric domains. Emigrating from one's native country can be stressful but navigating through the health care and legal system, and other immigration-related issues carry a cascading impact on both the physical and mental health of individuals. A third of psychiatrists in the U.S. are immigrants but many have significant immigration issues to contend with during their training. In this session, we will discuss some of the ways in which immigration-related issues can influence one's wellbeing during psychiatric training-both from the perspective of educators and trainees. An experienced training director will propose ways we might consider discussing immigration with trainees and promote wellbeing. We will also call attention to the benefits and challenges of discussing immigration issues with patients and share the data of 215 psychiatrists surveyed on their attitude towards talking about immigration status in the psychiatric encounter. Finally, we will describe what adequate mental healthcare looks like when addressing immigration-related mental health issues, especially in regards to

children. Participants will leave with a clearer understanding of, and practical recommendations on, immigration-related issues encountered in day-to-day training, practice and care delivery. Our panel of speakers is composed of experts in psychiatry training, practice and global mental health and are key members of renowned national and international organizations.

Adopting the Military for a Re-Parenting Experience: Psychosocial Development While Serving in the Armed Services

Chair: Randon Scott Welton, M.D.

Presenters: Daron Alan Watts, M.D., M.P.H., Terry L. Correll, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the combination of factors that bring volunteers into the armed services; 2) Explain the potential contribution the armed services make towards adult development; and 3) Correlate common military experiences with psychosocial stages of development

SUMMARY:

Currently 1.3 million uniformed members serve in the Department of Defense with an additional 41,000 in the United States Coast Guard. Active duty service has long been considered an attractive option for those with limited financial or educational prospects. Minorities and individuals with lower socio-economic backgrounds, academic performance, or a history of delinquency are more likely to enlist. Most recent recruits identified "Better my life" and nearly half included "To pay for future education" among their reasons for joining. Life in the armed services provides an opportunity for personal growth, which may be why adolescents from disrupted families or social networks are more likely to enlist. Most recruits reported gaining "Pride/self-esteem/honor" and "Develop Discipline" as motivating factors for signing up. This workshop will focus on the potential military service has for impacting individual psychosocial development. The presenters will demonstrate how the military struggles to act as a surrogate parent and thereby affects many of the psychosocial stages of development. A firm but supportive chain of

command can provide psychological functions such as a “holding environment”, and “emotional containment” for some while others perceive it as suffocating and controlling. The military esteems those who show creativity and are productive while working within a clearly defined structure. Too much initiative and autonomy, however, will not be tolerated. The interpersonal relationships within units can be incredibly intimate and nurturing, but some experience them as intrusive and phony. Extended military service provides some individuals with the ability to look back on a career that was well spent while others see themselves simply as replaceable cogs in an impersonal machine. The interactions among the individual’s personal history and stage of development, the unit that surrounds them, and the armed service’s structure determine the valence and value of these experiences in the military. Attendees will be asked to relate their experiences in the armed service or working with active duty/veteran patients in order to explore, confirm, or refute these concepts.

Air Pollution and the Brain: Impacts Across the Lifespan

Chair: Elizabeth Haase, M.D.

Presenters: Heather Volk, Jiu-Chiuan (J.C.) Chen, Pamela Lein

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the cumulative data about the neuropsychiatric impacts of air pollution; 2) Understand in greater depth recent research on the role of air pollution in the incidence of neurodevelopmental disorders and the progression of dementia; 3) Access cutting-edge research techniques for understanding interactions between environmental toxins such as air pollution and genetic susceptibility to illnesses with which air pollution has been asso; 4) Consider how air pollution compares to medical illnesses that influence neuropsychiatric illness; and 5) Discuss how the practicing psychiatrist who seeks to counsel the pregnant mother and aging patient about air pollution risks might approach such clinical discussions

SUMMARY:

An increasing body of literature affirms significantly increased risks of neuropsychiatric symptoms and associated clinical disorders across all age categories for those exposed to high levels of ambient air pollution. Our panel, comprised of leading researchers in this field, will present state-of-the-science data on the connection between air pollution exposure and neurodevelopmental and neurodegenerative disorders across the lifespan. Dr. Elizabeth Haase will serve as chair for the discussion, introducing the evidence base and its relevance to clinical psychiatry. The panel will then turn quickly to an in-depth review of some of the most important studies on air pollution neuropsychiatric impacts. Dr. Heather Volk will present her work about the impact of traffic-related air pollution on risk for autism and behavioral disorders, including ADHD. Dr. Jiu-Chiuan (J.C.) Chen will present his translational and epidemiological work investigating the neuropsychological processes and neuroanatomic structural changes leading to an increased risk for dementia with air pollution exposure in the Women’s Health Initiative Memory Study. Dr. Pamela Lein will present on new preclinical models for investigating effects of traffic-related air pollution on neurodevelopmental disorders and neurodegenerative disease. The panelists will conclude with an audience discussion of the relevance of this database to the emerging “silver tsunami” of aging Americans compared with other risk factors for neurodegeneration . We will discuss how the American Psychiatric Association and the practicing psychiatrist might respond to awareness of this emerging risk factor, ranging from support for air quality policy measures to strategies for mitigating exposure within a particular community or individual.

An Introduction to Motivational Interviewing as a Core Communication Style and a Potentially Transformative Way of Seeing Your Job

Chair: Michael A. Flaum, M.D.

Presenters: Florence Chanut, M.D., Brian Hurley, M.D., M.B.A., Carla B. Marienfeld, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to explain the meaning of the “paradoxical effects of

coercion”, and understand resolving ambivalence for positive change.; 2) Participants will be able to discuss the core components of the spirit of MI, the four “meta-processes” of MI, and the technical skills of MI; 3) Participants will improve their capacity to make simple and complex reflective listening statements; and 4) Participants will be able to discuss the consonance of the core components of the spirit of MI with those of mental health recovery

SUMMARY:

Motivational Interviewing was initially developed as an alternative approach to helping individuals with addictive disorders. Since its introduction in the 1980’s, its effectiveness has been demonstrated across a wide variety of disciplines and issues. Its uptake in general psychiatry has been relatively limited thus far in comparison to many other fields, which is surprising in light of its potential utility in common problems in psychiatric settings such as medication non-adherence. This workshop is designed to open up a discussion about alternative ways of communicating and relating with our patients in psychiatry. The session will introduce participants to the fundamentals of motivational interviewing (MI) emphasizing the “paradoxical effect of coercion”. This idea leads to what is unique in MI relative to other counseling styles, which is the overt effort to structure the conversation such that it is the patient rather than the clinician who is making the argument for change. The rationale for this idea will be presented and its impact discussed. The session will be interactive, with brief exercises that demonstrate some of the basic techniques of MI, with a focus on reflective listening. We will also discuss the core elements of the so-called “spirit of MI” and highlight the consonance of those elements with those of a patient-centered, recovery orientation. Although MI was developed in an effort to help people change problematic behaviors, we will suggest that it can also be a very useful default communication style and “way of being” with our patients. It is a potentially paradigm-shifting approach that may cast a very different light on how we see and experience our job, and how we choose to spend our limited time with our patients. While this workshop is open to all, it is intended especially for those who have had limited exposure to motivational interviewing.

Anatomy of a Lawsuit

Chair: Catherine R. Mier, M.D.

Presenter: Swati S. Shivale

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To give attendees a better understanding of the complex, multivariate reasons why some adverse outcomes result in a malpractice claim and others do not; 2) To educate attendees about the framework and stages of a malpractice case and provide psychiatrists with an understanding of what their role would be during a prospective malpractice case; 3) To provide advice from attorneys and insurance executives about things a physician should do (or not do) during a malpractice case; 4) To give attendees tools for good self-care while in the process of a lawsuit; and 5) To allow attendees the opportunity to ask questions about a difficult subject that is rarely addressed in an open and forthright manner

SUMMARY:

Medical malpractice lawsuits are a common experience for physicians. A recent survey published by Medscape found that 55% of all physicians had been sued at some point in their career [1]. The vast majority of these claims, approximately 80% by most measures, do not result in payment to the claimant[2]. However, these lawsuits are resource intensive, both in terms of the time that must be devoted to their resolution, and the stress associated with the lawsuit itself. In addition, the fact that most lawsuits require more than a year to reach resolution, means that the physician will have to revisit the heartache that comes with a bad clinical outcome, regardless of fault, over an extended period of time[3, 4]. Despite the ubiquity of malpractice lawsuits, scant amount of time is dedicated to teaching psychiatrists, particularly those who are early in their career about what a malpractice suit involves[5]. Although considerable time and effort is spent pondering and implementing practices meant to decrease the potential of a medical malpractice lawsuit, there is considerably less education available on what will happen after a claim is filed. In addition, what information there is available is often hearsay or frankly wrong. Using

redacted hospital records, news coverage, and court room video, *Anatomy of a Lawsuit* will present a case study of a patient suicide and a resulting malpractice suit. Using the case as a narrative framework, the presentation will educate attendees about each aspect of a malpractice claim. It will also provide advice from attorneys specializing in malpractice defense, and executives from malpractice insurance companies about how to navigate the process of being sued. Lastly, it will offer advice from physicians who have been sued about what to expect, and how to maintain both personal health and professional enthusiasm during an intense and difficult challenge.

Anatomy of a Podcast: A Case Study of PsychEd, a Psychiatry Education Podcast “For Medical Learners, by Medical Learners”

Chairs: Alex Raben, M.D., Sarah Hanafi, M.D., B.Sc.
Presenters: Bruce Alexander Fage, M.D., Lucy Chen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the use of podcasts in medical and psychiatry education, based on the current literature; 2) Critique podcasts as an educational delivery platform by comparing its strengths and weakness to more traditional, teaching methods; 3) Evaluate using podcasts in their own learning, curriculum design, and lesson planning; and 4) Propose solutions to existing challenges in podcasting in psychiatry

SUMMARY:

PsychEd is a psychiatry education podcast made by medical learners, for medical learners. It is one of the first podcasts of its kind in the field of psychiatry and has grown to a worldwide audience of over 1000 downloads monthly per episode. Despite this success, much remains unexplored in the literature on podcasts for medical education, with even scantly literature on podcasts for psychiatry education. In this session, we will dive deeper into the meaning and utility of podcasts in medical education and then more specifically in psychiatry, using PsychEd as a case study. First, we will present the results of a narrative literature review that sheds light on the current landscape of medical podcasts,

the epidemiology of use, and the current evidence for their utility and efficacy in medical education. Second, we will present data and narrative derived from our experience with PsychEd. This will include an overview of our story from origin until now, listener statistics and preliminary data from our own research study of PsychEd. Our study uses an online survey with semi-structured interviews to answer the research question “How are learners using and experiencing a psychiatric educational podcast?” We have had 97 survey responses to date; thus far, the data show that, although we have many medical student and psychiatry resident listeners, our audience is quite diverse in educational background. The data also suggests that listeners find the episodes to be useful not only for their own knowledge but for clinical applications as well. Our qualitative data provides insight into use patterns and new findings on listener preferences for episodes. Our findings represent some of the first research in this area and begin to answer some fundamental questions about the educational goals and type of content that draws psychiatry learners to podcasts. Audience participation will be facilitated by small group sessions, wherein participants will reflect on how podcasts can supplement education in their own institutions, as well as the potential disadvantages of and challenges in podcasting. Finally, we will facilitate a creative breakout session where participants will collaborate to tackle the challenges of podcast creation, implementation, or evaluation. We hope this talk will stimulate discussion and future research around this new teaching tool in psychiatry and how educators and learners alike can use it.

Appropriate Use of Benzodiazepines in Special Populations

Chair: Edward Kenneth Silberman, M.D.
Presenters: Richard Balon, M.D., Vlado Starcevic, M.D., Carl Salzman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to summarize the evidence about general liabilities of benzodiazepine medications.; 2) Participants will be able to list indications, liabilities, and guidelines for use of benzodiazepines in older patients.; 3)

Participants will be able to list basic principles of using benzodiazepines in medically ill patients.; and 4) Participants will be able to summarize the evidence about liabilities for using benzodiazepines in patients with past histories of substance abuse.

SUMMARY:

This presentation aims to inform participants about indications, benefits, liabilities and clinical guidelines for use of benzodiazepine medications in special populations - areas where the current evidence base may be under-appreciated and an older literature forgotten. Populations highlighted in this presentation are: older patients with anxiety; medically ill patients; and patients with anxiety disorders who have a past history of substance abuse. Use of benzodiazepines in these patient groups will be discussed in the context of the scientific evidence base on general abuse/misuse potential and other liabilities of these medications, as well as the evidence specific to each population.

Bars, Footballs, and Totem Poles: Integrating Best Practice Guidelines and Existing Evidence When Making Decisions Regarding Benzodiazepines

Chairs: Jeffrey P. Guina, M.D., Brian Michael Merrill, M.D.

Presenters: Kimberly Stubbs, M.D., Jessica Porcelan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the history, mechanism of action, and theoretical principles of benzodiazepines; 2) Integrate the appropriate use of benzodiazepines for symptoms and specific DSM-5 diagnoses, including evidence of risks and benefits, and current practice guidelines in a large group discussion; 3) Synthesize clinical considerations when deciding whether to continue, discontinue or change treatment plans for patients already taking benzodiazepines in a small group discussion; 4) Construct safe practices when continuing or discontinuing benzodiazepines in both inpatient and outpatient settings; and 5) Apply practice guidelines and research findings in an innovative discussion about alternative treatment options for the management of both acute and chronic anxiety, insomnia and trauma-related sym

SUMMARY:

Benzodiazepines are a commonly prescribed class of medications that bind receptors at the GABA-A ligand-gated chloride channel complex and ultimately enhance the inhibitory effects of GABA. The inhibition of hyperactive stress-related brain structures makes benzodiazepines an attractive option for rapid sedation in the treatment of anxiety, insomnia, panic attacks, and stress- and trauma-related symptoms. However, the ubiquity of GABA throughout the central nervous system risks potential harm through both recreational use and iatrogenic effects. According to the Centers for Disease Control and Prevention, benzodiazepines were involved in approximately 30% of prescription overdose deaths in 2013. Perhaps less provocatively, additional evidence that aligns with cautious prescribing includes benzodiazepine-related inhibition of cognitive processing and emotional regulation. While over-prescription is a concern, an equally valid concern is that the rise of absolutist “no benzo” policies may be limiting access to those for which benzodiazepines are safe and effective. Both sides of this contentious debate will be discussed, considering clinical pros and cons as well as evidence-based risks and benefits. Prescribers have an obligation to assess cases on an individual basis and determine whether to continue, discontinue or change treatment plans for patients being prescribed benzodiazepines. Decision-making regarding prescribing should be based on efficacy for specific conditions, potential or existing adverse effects, risk of dependence or misuse, and history of other treatment trials. Discussions with patients regarding behavior changes and/or potential regimen changes are frequently met with resistance. Providers must be well-prepared to discuss management tools, monitoring (e.g., drug screening, state prescription databases), and alternative treatments, whether continuing or discontinuing benzodiazepines. It is important to consider precipitating factors leading to benzodiazepine misuse. In addition to facilitating a discussion about the above, our session offers an evidenced-based approach for management of anxiety and trauma-related symptoms. Best practice guidelines, and the pros and cons of various alternative treatments (e.g., psychotherapy, behavioral management,

serotonergic agents, antiadrenergics, and antihistamines) are considered.

Be in the Room Where It Happens: Engage Congress and Become a Powerful Advocate

Chairs: Robert Scott Benson, M.D., Jose P. Vito, M.D.

Presenters: Laura Willing, M.D., Sage Bauer, Kali D. Cyrus, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that being involved in the political process at all levels of government as an advocate is essential to protecting the safety of patients and the future of the psychiatric profession; 2) Learn and practice about the value-added government relation services that the APA provides to its members; and 3) Understand and identify concrete ways that every member become involved in advocacy at the local, state, and national levels

SUMMARY:

Psychiatrists speaking in the public arena are the most effective advocates for our profession whether engaged with a local family advocacy group or speaking in the halls of Congress. The APA encourages members to seek opportunities to be an advocate whether at the District Branch level or as a member of our Congressional Advocacy Network. These efforts have been successful in the past resulting in mental health parity laws, increased funding through Medicare/Medicaid, and protection of patients from the unsafe practice of medicine. The continued struggle to improve access to quality care demands that we have psychiatrist-advocates speaking to the issues. This workshop will provide insights into the legislative process, the development of talking points that provide a framework for presenting APA policy on the issues, and an opportunity to practice your advocacy skills.

Being Well: Building Resilience in Women Psychiatrists

Chair: Misty Charissa Richards, M.D.

Presenters: Auralyd Padilla Candelarario, M.D., Cassidy E. Zanko, M.D., Ranna I. Parekh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand concepts of wellbeing and resilience; 2) Explain the importance of maintaining a healthy work-life balance; 3) Describe the unique challenges facing female and minority psychiatrists; 4) Identify maladaptive habits early; and 5) Utilize resources and practice strategies to build resilience and improve wellbeing

SUMMARY:

The medical profession has undergone a significant demographic change, with a dramatic increase in the number of women applying to medical school and practicing medicine. The proportion of women physicians is now close to 40% in the majority of Western countries. However, this increase has not resulted in a redistribution of domestic tasks and responsibilities, placing women physicians at high risk for work-home conflict. Work-home conflict is one factor that significantly contributes to women physician's elevated risk for burnout, depression and suicide. This is highlighted in a recent APA survey which collected data on 1500 APA members. The preliminary findings reveal significant correlations between burnout and both female gender and lack of control over schedule. Understanding the challenges that women psychiatrist's encounter is critical to maintain wellbeing and build resilience. For example, women physicians have been shown to adhere to clinical guidelines and preventive care more than males, which results in increased patient visits and subsequently greater time with more psychosocially complex patients. While this may contribute to recent data that patients treated by women physicians have better 30-day mortality and readmission rates than those treated by males, this may also take a toll on women physician wellbeing. Hence, women psychiatrists must be able to identify warning signs and maladaptive habits early, maximize personal and professional development, and champion one another while balancing many important roles. Fostering resilience - the capacity to adapt successfully in the presence of risk and adversity, and bounce back from setbacks, trauma and high stress – is important when managing difficult situations. Resilience can also be a protective factor, reducing risk of psychiatric disorders that may occur after high stress or trauma. Additionally, members of historically excluded

groups often experience higher rates of stress than majority populations and, at times, live with chronic stress. Many women psychiatrists have developed intrinsic resilience on their paths to practicing medicine, though not all are aware that risk of burnout is reduced by spending at least 20% of time doing what they find meaningful. Additionally, evidence shows that women with a high degree of work control are 11 times more likely to report job satisfaction and to say they would again become a physician. This session will provide an overview of this important topic, review literature on wellbeing and resilience for women psychiatrists, and provide an opportunity for audience participation through case discussion or through sharing personal stories. We will describe resilience tools and foster interaction through practicing implementation. Participants will leave this session equipped with resources and strategies they can apply for the challenges discussed, and as general tools to improve well being.

“Bent-Nail” Research

Chair: Glenda L. Wrenn, M.D.

Presenter: Carl Compton Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Name the three types of knowledge; 2) Differentiate between psychosocial and biotechnical prevention; and 3) Understand the importance of bent-nail research for Non-White populations

SUMMARY:

In 2001, the 16th US Surgeon General’s Culture, Race, and Ethnicity report noted there was a dearth of research on African-Americans. This lack of formal scientific inquiry into legitimate African-American health, mental health, and wellness issues has plagued the US for centuries and continues to the present day. In this presentation, Dr. Bell proposes a solution of doing rudimentary clinical research, i.e. “bent-nail research” to address the problem of the paucity of research that has plagued the African-American community since he was a medical student at Meharry Medical College 50 years ago. Dr. Bell will explain the concept of “bent-nail” research as a metaphor from Dr. Bell’s childhood experiences

when he would try to build things but did not have proper material or tools, accordingly everything he built was done using straightened bent-nails, but it was functional. Dr. Bell points out there are three basic ways of knowing: 1) we can know things rationally by thinking about them; 2) we can know empirically which is knowledge based on our perceptions; and 3) the third way of knowing is metaphorically in which we grasp things intuitively – it is in the metaphor where one finds wisdom. Freud was doing “bent-nail” research when he began his investigations of psychoanalysis but the mechanisms behind his observations have not been elucidated until recent neuroanatomy, neurochemistry, and neurocircuitry have been explicated by modern science. Freud’s theories and metaphors have been found to represent the dynamic interplay between the Cerebral Cortex and the seven neurocircuits of the midbrain Interestingly enough these are the same behaviors anthropologist Desmond Morris discussed in his Award winning book *The Naked Ape* and which have fascinated mankind since the dawn of our time. Another “bent-nail” researcher was Charles Vert Willie, Ph.D., Harvard Professor of Sociology, who explored the adaptation processes by middle-class, working-class, and low-income Black families, by using case studies written by former students at Harvard, will be highlighted. Finally, Dr. Bell will catalogue his “bent-nail” research beginning in medical school, and underscore the outcomes of those studies, many of which have gone on to secure funding from various organizations and proven to provide directionally correct understandings of African-American mental health and wellness issues. It is proposed by doing more “bent-nail” research, the shortage of knowledge on People of Color’s cultural, social, psychological and biological psychiatric dynamics can be corrected.

“Brain Drain”: What Is Psychiatrists’ Workforce Migration and What Can We Do About It?

Chairs: Maria Mirabela Bodic, M.D., Mariana Pinto Da Costa

Presenters: Anna Szczegielniak, Ayana Jordan, M.D., Ph.D., Afzal Javed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Recognize the workforce

migration (Brain Drain) as a significant international problem; 2) 2. Name three initiatives in which the WPA, the European Federation of Psychiatric Trainees and the APA are attempting to quantify and describe t; and 3) 3. Name three proposed solutions to address the challenges caused by workforce migration

SUMMARY:

Immigration (or brain drain) of health professionals, is a significant concern to many countries, particularly from Low-and Middle-Income Countries (LMIC), with great impact on infrastructures and services, being a major factor to the difficulty to provide adequate health service to the population. In regard to mental health, migration of specialists may pose particular problems for developing countries due to the relatively poorer development of their services and the paucity of these specialists. We aim to discuss migration and its impact, recognizing the push factors that pressure people to leave the donor country, the pull factors that make the recipient country seem attractive, while verifying patterns and duration of these flows. We will provide an overview of migration and the different cultural challenges faced on the way to a psychiatry career, from the starting period of the training and present the results of the World Psychiatry Association (WPA) Task Force established in 2006 to examine issues related to this brain drain of psychiatrists from LMIC, while making recommendations to possible actions. Afterwards, as an attempt to explore migration among psychiatry trainees, the European Federation of Psychiatry Trainees (EFPT) prepared a survey to assess opinions and experiences of international migration. This has now been extended to survey psychiatric trainees and Early Career Psychiatrists across the world. Audience opinions on the topic and attitudes will be explored with a poll system. This debate may raise awareness on what are the current trends, help to elucidate the underlying issues, recommend possible systems of support and generate further directions in the migration of mental health professionals.

Can M&Ms Be “Sweet” for Psychiatry: A Symposium and Discussion of the Role of Morbidity and Mortality Conferences in Academic Psychiatry
Chair: Anna Pearl Shapiro, M.D.

Presenters: Ryan Rajaram, M.D., Isabel N. Schuermeyer, M.D., Osamu de Diana Iyoha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) By the end of this session participants will be able to demonstrate an understanding of the history of morbidity and mortality conferences in the field of medicine and their importance for patient care; 2) Participants will experience a morbidity and mortality conference and be able to actively participate in discussion of the case.; 3) By the end of the session, participants will be able to conduct their own morbidity and mortality conference in a neutral, open manner.; and 4) Participants will be able to demonstrate an understanding of the controversies surrounding morbidity and mortality conference and the psychiatrist’s role in an morbidity and mortality discussion.

SUMMARY:

Morbidity and mortality (M&M) conferences are commonplace activities within the field of medicine and often held weekly in specialties such as surgery, internal medicine and pediatrics. However, they are a much less common phenomenon in the field of psychiatry. While psychiatry has relatively low rates of mortality it does have relatively high rates of morbidity resulting in poor quality of life for patients. This morbidity can be attributed to a number of factors including socio/economic issues, legal issues, stigma against mental illness and misinterpretation of symptoms by colleagues inside and outside the field of psychiatry. Due to this, we argue that the need for M&M’s in the field of psychiatry is essential, and resident education in this practice is a necessary part of our curriculum. Since 2016, the psychiatry residency program at Cleveland Clinic Foundation has been organizing quarterly M&M conferences that are led by the residents and moderated by faculty. These conferences have addressed a variety of medical and psychiatric issues that have arisen within our hospital system. Typical M&M rounds include a description of the case and a thorough discussion of the multidimensional issues that may have led to an undesirable outcome concerning a particular case or patient. A ‘safe’ environment is created, where participants are

encouraged to share their thoughts among their peers, without judgement or blaming others. The rules and guidelines are presented prior to discussion, and moderators ensure that the rounds remain civil and to minimize judgement while remaining constructive and practical. Ultimately, the goal of these rounds is to create an environment rich for learning and open communication. In this session we will discuss the importance of M&M conferences in the setting of an academic psychiatry department. We will review the history of M&M's and will discuss possible hypotheses regarding the lack of M&M conferences in the academic psychiatry setting. Finally, we will present an example of an M&M conference. During this HIGHLY INTERACTIVE session, we will engage the audience in discussion of the case and opportunities for improvement. This will allow the audience to experience the manner in which our M&M conferences are conducted. We hope to demonstrate how an M&M can be led in a neutral, open manner and perhaps inspire a "reconciliation" between M&M's and psychiatry.

Ceci N'est Pas Freud: A Guide Into Psychodynamic Education by Residents, for Residents

Chairs: Razieh Adabimohazab, M.D., Ali Maher Haidar, M.D.

Presenters: Saumya Rachakonda, M.D., Vivian Chan, D.O., M.S., Elham Rahmani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the role of psychodynamic theory in driving psychiatric patients' presenting signs and symptoms; 2) Identify the manifestations of transference and countertransference in resident-patient interactions in different treatment setting; 3) Discuss resident initiatives at integrating dynamic theory into their residency training curriculum even in geographic areas without Psychoanalytic Institutes; 4) Express the utility of psychodynamic principles in community treatment practice and in caring for the severely mentally ill including psychotic spectrum disorders; and 5) Review clinical material and cases demonstrating psychodynamic treatment principles presented by residents

SUMMARY:

Psychiatry is a vibrant field that is constantly changing. Previously a predominant practice, psychoanalysis has taken the back seat as more biologically driven models advanced. However we argue that there still is value for psychodynamic therapy in modern psychiatric practices and particularly in residency education. Despite the common belief that psychodynamic approaches are mainly suitable for intellectual and high functioning neurotic individuals, psychodynamic perspectives remain extremely helpful in treating patients in the borderline and psychotic spectrums of mental illness. We present our experience as residents working in urban community tertiary centers, where we provide psychodynamically guided care to the severely mentally ill population. We will share our different experiences in using psychodynamic theories in various clinical settings including inpatient, community outpatient, and personality disorder clinics. During the course of working with psychiatric patients, most of us develop various emotions to patients' symptoms which is a phenomenon known as countertransference. As residents with different cultural and racial backgrounds treating equally diverse patients, we will share different personal clinical experiences regarding transference and countertransference. Audience will be asked to interact and share their thoughts and approaches had they been exposed to the presented clinical vignettes. Additionally, psychoanalytic theory has recently been finding its way back into major institutes. Despite that, biological approaches still dominate psychotherapy and psychoanalysis in most training institutes of the United States. We will demonstrate in our panel the struggle some residents are facing in regards to finding educational and supervision resources in areas with less focus on dynamic principles. On the other hand, residents from two different institutes in New York will share how they have been able to actively seek opportunities to integrate psychodynamic theories into their educational curriculum. Our panel will include current psychiatry residents from 3 different institutions and represent different levels of training (PGY 2-4) with different backgrounds in American and International medical schools.

Clozapine Management in Medically Complex SMI

Population: Perspectives on Coordination of Care

Chair: Laura A. Clarke, M.D.

*Presenters: Nery Diaz, D.O., Olivia M. Joly, M.D.,
Laura A. Clarke, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the management of clozapine in the SMI population with complicated medical diseases; 2) Understand monitoring benign ethnic neutropenia (BEN) for patients on clozapine; 3) Understand the cardiac risk associated with clozapine; 4) Engage medical specialty services in the management of SMI patients that are on treatment with clozapine; and 5) Evaluate the risk and benefits for serious mental illness

SUMMARY:

Clozapine is the preferred treatment for refractory symptoms of Schizophrenia. However, the frequency of clozapine use remains low. Practitioners may be concerned by the side effect profile of clozapine, especially in the medically ill patient. The goal of this presentation is to demystify the clinical management of clozapine in populations with schizophrenia and serious medical illness. The speakers are expert clinicians from community mental health clinics and long term psychiatric centers. Teaching techniques will employ brief case presentations to illustrate the management of clozapine in patients with medical illness, such as hematology and cardiovascular disease. The presentation will highlight the importance of engaging specialty medical services in the management of co-occurring medical diagnosis as a means of supporting the use of clozapine in the population with serious mental illness. Didactic teaching will also be employed as part of the presentation. We will conclude with a discussion on the risk benefit analysis for the use of clozapine. Time will be allocated at the end of the presentation for comments and questions from our audience.

Complex Decisional Capacity Assessments: From Disposition, to Organ Donation, and Death

Chairs: Vivek Datta, M.D., M.P.H., James Alan Bourgeois, M.D., O.D.

Presenters: Lawrence Edward Kaplan, D.O., Panid Sharifnia, M.D., Ph.D., James Armontrout, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how dispositional capacity differs from other dispositional capacity evaluations; 2) Perform a capacity evaluation for physician assisted dying; 3) Recognize the special challenges posed for psychiatrists in evaluating living organ donors; 4) Reflect on the ethics of psychiatrists participation in decisional capacity for organ donation after cardiac death in patients with Amyotrophic Lateral Sclerosis; and 5) Critically assess the research literature on the reliability of psychiatrists' determinations of patient capacity to make medical decisions

SUMMARY:

While all physicians are expected to be able to make an assessment of patients' capacity to make medical decisions, consultation-liaison psychiatrists are often asked to make such determinations. In many cases, these evaluations transform medicolegal and ethical questions into psychiatric ones. In this lively and interactive session of rapid-fire talks, we will assess some special forms of capacity evaluations that present particular challenges for psychiatrists. First, we will discuss the psychiatrist's role in determining patient's role in making dispositional decisions (i.e. capacity determinations of self-care post-discharge), how dispositional capacity differs from medical decisional capacity, and describe a biopsychosociocultural framework for performing such evaluations. Second, we will discuss the psychiatrist's role in physician assisted dying. As more states legalize physician assisted dying, psychiatrists will take on an important and challenging role of assessing patient's capacity to consent to physician assisted dying. Since California's End of Life Option Act was passed in 2015, the University of California San Francisco Medical Center has become the only institution in the United States to mandate a psychiatric evaluation for all patients who opt for physician assisted dying. We will outline the framework used at this institution, and discuss the experience of the first three years of this approach, its strengths and limitations. Third, we will discuss the psychiatric evaluation of living organ donors. As living organ donation becomes more generally accepted, a larger proportion of the

general population – including those with psychiatric disorders – are being evaluated for live kidney and partial liver organ donation. We will discuss the special challenges of assessing donative capacity and its intersection with other elements of the psychiatric evaluation for living donors. Fourth, we will reflect upon the ethical challenges that exist when psychiatrists are called upon to evaluate capacity for organ donation after cardiac death in ventilator-dependent patients with amyotrophic lateral sclerosis. Finally, we will discuss the elephant in the room: the low levels of agreement between assessors, including psychiatrists, when determining decisional capacity in gray area cases. We will review the research in this area, and the implications for clinical practice as they pertain to more challenging capacity assessments.

Disrupting the Status Quo: Intensive Mobile Treatment Teams, an Innovative Model for Engagement

Chair: Myla Harrison, M.D.

Presenters: Janine Perazzo, L.C.S.W., Roshni Misra, L.C.S.W., Serena Yuan Volpp, M.D., M.P.H., Joy Kang, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the key principles and practices of the Intensive Mobile Treatment Team Model; 2) Recognize the importance of the Local Government Unit partnering with Community Based Providers to create new models of treatment; and 3) Understand the challenges of measuring success with a difficult-to-engage cohort of individuals across systems

SUMMARY:

Throughout the US, a small percentage of people with multiple needs use a disproportionate amount of resources, in part due to disconnections from care. As people disconnect from mental health services, a vicious cycle of alienation and failed engagement perpetuates itself. Best practices for engaging this high service use population for extended periods of time do not exist. Under a newly launched mayoral mental health initiative, the New York City Department of Health and Mental Hygiene (DOHMH) developed, in partnership with

three community agencies, a new model of service called Intensive Mobile Treatment (IMT). We describe this mobile, flexible and interdisciplinary engagement and treatment model designed to improve outcomes for people with complex cross-systems involvement. Eligible individuals have a history of unstable housing, multiple behavioral health conditions including co-occurring substance use, repeated involvement in the criminal justice system, and/or prior disengagement from behavioral health services. The main principles: succeed in engagement at all cost, with no time limit on length or number of encounters, individualize interventions to meet the person's life goals with no discharge date, and provide mobile service delivery that follows the person— whether to jail, shelter, hospital, or elsewhere. This approach includes a team of peers and traditional mental health workers. The 3 IMT teams created for the pilot each delivered services to 25 individuals at a time, taking time to engage people, meet their needs and provide intensive care without a directive to transition individuals to lower levels of care. Teams collected data and submitted the data to DOHMH. We will discuss the intersection of this model with existing services in NYC, such as court-mandated Assisted Outpatient Treatment. We will share real-life vignettes to discuss with the audience successes and struggles, data on process and outcomes for the 3 pilot IMT teams, as well as the sustainability challenges of this model.

Diversifying Our Understanding of ADHD: Beyond Stimulants and School Challenges

Chair: Ryan Smith Sultan, M.D.

Presenters: Justin W. Mohatt, M.D., John T. Walkup, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate how current conceptualizations of ADHD focus primarily symptoms and academic concerns; 2) Understand the range of morbidity risks and comorbid conditions associated with ADHD; 3) Describe and Compare the evidence base supporting or refuting the use of common and emerging alternative treatments for ADHD; and 4) Discuss the variety of relationships of

ADHD to co-occurring conditions and the role of diagnostic assessment

SUMMARY:

Attention Deficit/Hyperactive Disorder (ADHD) is the most common neurodevelopmental disorder in childhood with U.S. community prevalence estimates as high as 8.6% and active treatment rates of approximately 69%. Symptoms generate clinically significant functional impairments, and persist into adulthood with ~65% of cases with high levels of morbidity and risk for the development of comorbid conditions. In the U.S., community practice ADHD evaluation concentrates on symptom-based rating scales, such as the SNAP-IV, that only evaluate hyperactivity, inattention, and impulsivity. Concurrently, treatment focuses on stimulant medication dosing and educational interventions. Yet there is limited attention to the morbid risks of ADHD, such as motor vehicle accidents, suicidality, and use of public assistance programs. Further, common comorbid conditions include Autism Spectrum Disorders (ASD), anxiety and mood disorders have their own morbidity risks and treatment needs. Stimulant treatment of ADHD is common and effective but increasingly families and prescribers are interested in alternative treatments, such as Omega-3 and neurofeedback. Yet much of this knowledge remains absent from current ADHD practice guidelines. This Perspective will expand and diversify clinician's knowledge by examining the evidence of ADHD's impact beyond symptoms and academic function. Specifically, long term morbidity risks, alternative treatments and evaluation/management of comorbid conditions in ADHD.

Duties of Creating Options for Veterans' Expedited Recovery (COVER) Commission: Evidence-Based Care and Complementary and Integrative Health

Chair: Shira Maguen, Ph.D.

Presenters: Marsden Hamilton McGuire, M.D., Wayne Jonas, M.D., Michael Potoczniak, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe why the COVER Commission was established; 2) Discuss the structure of the COVER Commission; 3) Describe the

scope of duties of the COVER Commission; and 4) Discuss the scope of complementary and integrative medicine modalities being considered for use in mental care at the Veterans Health Administration

SUMMARY:

The COVER Commission was established as part of the Comprehensive Addiction and Recovery Act of 2016 (CARA), functioning under the Federal Advisory Committee Act (FACA). The main goals of the COVER Commission are to examine the Veterans Health Administration's evidence-based therapy model for treating mental health conditions as well as the benefits of incorporating complementary and integrative health (CIH) treatments with the goal of improving mental health conditions. More specifically, the five tasks of the COVER Commission are: (1) To examine the efficacy of the current VHA evidence-based therapy model; (2) To conduct a Veterans' survey to better understand current experiences with and preferences for VHA and non-VHA mental healthcare as well as use of CIH treatment for mental health conditions; (3) To examine the evidence-base for CIH modalities as additional treatments for mental health conditions and make recommendations about whether these can be helpful for Veterans with mental health conditions; (4) To evaluate VA resources to ensure their adequacy to treat mental health conditions; and (5) To examine current resources and treatments to determine whether these adequately address the suicide rates among Veterans, ability to treat Veterans with current MH conditions, and availability to expand CIH modalities. During this forum, we will present on the scope of the COVER Commission's duties and engage audience members in a discussion about their thoughts about these specific duties as well as perspectives on these duties from their own experiences in the mental health field. The group will engage in a discussion about optimizing care for Veterans with mental health diagnoses and how to ensure that care is comprehensive and meeting the needs of Veterans in and out of VHA Care. We will also specifically ask the audience to discuss their perspectives on engaging Veterans who are at highest risk and may not seek MH treatment as well as their experiences with integrating CIH treatments into mental healthcare.

EEG in Psychiatric Practice

Chairs: Oliver Pogarell, M.D., Nashaat Nessim Boutros, M.D.

Presenters: Oliver Pogarell, M.D., Nashaat Nessim Boutros, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the clinical EEG as auxiliary diagnostic tool in psychiatry; 2) Decide whether a clinical EEG is indicated for a particular patient; and 3) Identify abnormalities and clinical consequences

SUMMARY:

EEG remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this interactive session clinicians will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns. Specific clinical indicators ("red flags") for EEG assessment will be stressed. More detailed coverage of selected areas will include: (1) EEG in psychiatric assessments in the emergency department; (2) EEG in the assessment of panic and borderline patients; (3) the value of EEG in clinical presentations where diagnostic blurring occurs (i.e. differential diagnosis of dementia, differential diagnosis of the agitated and disorganized psychotic patient, and psychiatric manifestations of non-convulsive status epilepticus). Specific flow charts for EEG evaluations with neuropsychiatric patients will be provided. Numerous illustrated clinical vignettes will dramatize points being made. This course is intended for the practicing clinician. In conclusion, the presentation is designed to enable the practicing clinician to utilize EEG effectively (i.e. avoid over- or under-utilization), to help with the differential diagnostic question and to be able to determine when an EEG test was adequately (technically) performed. At the conclusion of this session, the participant should be able to understand the limitations of EEG and broad

categories of pathophysiology that produce EEG abnormalities. The participants will have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG. Attendees will also develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy.

Engaging and Partnering With Faith Communities and Spiritual Care Professionals to Revitalize Mental Health Care: An Underrecognized Innovation

Chair: Wai Lun Alan Fung, M.D.

Presenters: Amy Porfiri, James Lamont Griffith, M.D., Alexis Lighten Wesley, M.D., Mary Lynn Dell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the theoretical and ethical bases of the partnership between mental health and faith communities/spiritual care professionals, in attaining high quality, person-centered mental health care; 2) Appreciate the work of the APA Mental Health and Faith Community Partnership as a leading force in such partnerships in the United States; 3) Discuss the roles of national and international psychiatric associations, as well as local grassroots organizations, in promoting such partnerships/collaborations.; 4) Describe examples of such partnerships in addressing mental health needs of cultural minority groups, rural and socioeconomically disadvantaged groups, and children and adolescents.; and 5) Appreciate the opportunities and challenges of such partnerships.

SUMMARY:

Faith communities and spiritual care professionals have long played instrumental though often under-recognized roles in promoting mental health. The World Psychiatric Association (WPA) states that, "Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities..., in support of the well-being of their patients." (Moreira-Almeida et al, 2016). In acknowledgement of this importance, the American Psychiatric Association (APA) had convened the "Mental Health and Faith Community Partnership" in 2014 (www.psychiatry.org/faith). In this proposed session, 5 speakers will present various aspects of

such partnerships that help revitalize mental health care – especially among cultural minority groups, rural and socioeconomically disadvantaged groups, and children and adolescents. Dr. Alan Fung (Secretary of APA Caucus on Spirituality, Religion and Psychiatry; Board Member of WPA Section on Religion/Spirituality) will begin by providing an overview of such collaborations between mental health and faith communities – illustrated by his collaborations with the Christian and Muslim communities in Canada. Thereafter, Ms. Amy Porfiri (Deputy Director of APA Foundation and key APA staff for the Mental Health and Faith Community Partnership) will present the background, achievements to date and future directions of the Partnership. Third, Dr. James Griffith (2017 Oskar Pfister Awardee) will describe the APA-sponsored “Promoting Mental Health in Central Appalachia” project – illustrating how partnerships between psychiatrists and faith communities can enhance access to mental health services in underserved rural regions that have high rates of depression, suicide and prescription drug abuse. Fourth, Dr. Alexis Wesley (APA/SAMHSA Fellow, supervised by Dr. Griffith) will present on a program of psychiatric consultation to pastors representing 13 African American churches in Washington, D.C. – as African Americans are more likely to suffer from serious mental health problems but they largely underutilize traditional mental health services – and much of this service gap is filled by clergy in predominantly African American churches. Fifth, Dr. Mary Lynn Dell (Vice Chair of the APA Caucus), who is both a child psychiatrist and ordained clergy, will provide her perspectives on how collaborations with faith communities could help address the severe shortage of child and adolescent mental health services – as clergy and youth leaders in congregations know and care for youth over many years and through many of life’s difficult situations – and they often serve as the ‘mental health gatekeepers’. Dr. Fung will conclude the session by presenting on the progress by the APA Caucus in updating and expanding on the 2006 APA Resource Document on Religious/Spiritual Commitments and Psychiatric Practice – in order to encourage such mental health and faith community partnerships.

Environmental Factors in Adolescent Development: Emerging Findings From the ABCD Study

Chairs: Gayathri Dowling, Ph.D., Lindsay Squeglia, Ph.D.

Presenters: Elizabeth Sowell, Ph.D., Martin Paulus, M.D., Natasha Wade, Ph.D., Wesley K. Thompson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the design and assessment procedures being used by the ABCD study and the resulting data available for the scientific community; 2) Describe preliminary data of the impact of various environmental exposures on brain, cognitive, and psychosocial development from the interim ABCD baseline cohort; and 3) Appreciate the genetic and environmental data available from ABCD and how it may be used to understand the role of gene by environment interactions in adolescent development

SUMMARY:

The Adolescent Brain Cognitive Development (ABCD) study is a multi-site longitudinal study of more than 11,000 youth starting at age 9-10 designed to increase our understanding of how diverse experiences influence adolescent development. Youth and their families complete comprehensive assessments of physical and mental health, substance use, environment, and cognitive function as well as biospecimen collection and structural and functional brain imaging. This session will outline the study design, the demographic characteristics of the cohort, and emerging findings about the influence of environmental factors and gene by environment interactions on brain, cognitive, and psychological development. Environmental exposures can be quite diverse, ranging from community (e.g., lead) to family (e.g., stress) to individual (e.g., screen time) level exposures. The ABCD study is collecting information about environmental exposures across these levels. Preliminary findings demonstrate that high family stress is associated with lower total cortical volume and surface area, as well as poorer cognitive performance in youth, independent of age, sex, race, parental marital status, and socioeconomic status (SES). Similarly, estimated risk of lead exposure was significantly and negatively associated

with both total cortical volume and cognitive performance in youth; however, SES significantly moderated these relationships. Screen media activity (SMA) is a major recreational activity for youth. Preliminary analyses reveal that youth with more general SMA report higher family conflict and more sleep disturbance. Surprisingly, youth engaging predominately in social media activity reported more physical activity and less family conflict, demonstrating that SMA is not uniformly associated with poor outcomes. Preliminary fMRI data reveals that higher levels of SMA are related to greater BOLD signal with correct performance on the stop signal task in the left anterior cingulate cortex and right frontal pole. On the emotional 2-back task, those with more SMA also had higher BOLD signal in left and right superior frontal and right caudal middle frontal regions. These findings suggest greater screen exposure is associated with higher neural activation in regions important for behavioral inhibition and cognitive control in children. Finally, there is also a strong genetic component to the study. Polygenic scores for educational achievement were computed and associated with a neurocognitive battery of outcomes, explaining 10% or more of the variation in these phenotypes after controlling for genetic ancestry. The degree to which these genetic effects on neurocognition are mediated by brain function and structure and the moderating role environment plays in these relationships will also be explored. Collectively, these data demonstrate the value of the ABCD study dataset for answering myriad questions about the role of genes and the environment on adolescent development.

Ethical Issues and Capacity Assessments in Obstetrical Patients

Chair: Anna Glezer, M.D.

Presenters: Susan Joy Hatters-Friedman, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review ethical principles and recognize how these apply to pregnant patients; 2) Identify different contributing factors to the assessment of a pregnant patients' capacity; and 3)

Practice evaluating difficult cases through the lens of ethical principles

SUMMARY:

Recently in certain parts of the country, we have seen a shift in the way society, its laws, and the medical community respond to pregnant women. Where the focus had been on the pregnant woman and her well-being, the focus now has shifted to the baby, and at times, the well-being of the fetus at the expense of the mother. This is evident in the hot dialogue around the country on topics such as abortion and substance use in pregnant woman, as well as in medical communities on issues like court ordered cesarean sections and involuntary medication of pregnant patients. In this session, participants will review the ethical principles that guide medical and mental health practice and begin to apply those to pregnant patients using examples of difficult cases presented by the authors as well as those gathered from the audience.

Ethics Dilemmas in Psychiatric Practice

Chair: Ezra E. H. Griffith, M.D.

Presenters: Rebecca W. Brendel, M.D., J.D., Richard P. Martinez, M.D., Stephen C. Scheiber, M.D., Charles Dike, MB.Ch.B., M.P.H., Tia Powell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize ethics dilemmas and common situations that may signal professional risk; 2) Inform APA members of the ethics resources available to them through the Association; 3) Identify boundary issues and conflicts of interest; and 4) Identify practical resolutions to ethics dilemmas

SUMMARY:

This workshop will be entirely devoted to the APA Ethics Committee members' taking questions from the audience on ethics dilemmas they have encountered, participated in, or read about. Audience interaction will be encouraged, and ensuing discussions will be mutually driven by audience members and Ethics Committee members. All questions related to ethics in psychiatric practice will be welcomed. Possible topics might include boundary issues, conflicts of interest, confidentiality,

child and adolescent problems, dual agency conflicts, acceptance of gifts, emergency situations, trainee issues, impaired colleagues, and forensic matters.

Evidence-Based Spiritual Care: A New Paradigm for Health Care Chaplaincy

Presenter: George Fitchett

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the evidence-based spiritual care paradigm and arguments against it and in favor of it; 2) Describe 3 types of studies about religion or spiritual care and mental health that inform an evidence-based approach to spiritual care in mental health care; and 3) Summarize important next steps in advancing an evidence-based approach to spiritual care in mental health care

SUMMARY:

A new, evidence-based paradigm for spiritual care in healthcare has emerged in the 21st Century. Like evidence-based practice in other professions, the paradigm encourages chaplains to develop their spiritual care practice in the light of the best available research. Multiple factors have contributed to the emergence of this paradigm, including cultural changes in religion and spirituality, healthcare systems becoming more data driven, and the growth of research about religion/spirituality and health. Arguments against the paradigm have been advanced but in general it has been embraced by chaplaincy leaders, professional chaplaincy organizations and rank and file chaplains. There is a growing body of research that can inform spiritual care for people with mental illness. The presentation will review a sample of recent studies that may inform spiritual care including reports that illustrate major study designs: case studies, qualitative studies, longitudinal studies of patients receiving treatment, RCTs, and systematic reviews. The review will highlight important themes from the research about religion/spirituality and coping with mental illness. The existing research notwithstanding, much work remains to be done to support an evidence-based approach to spiritual care for people with mental illness. Priorities for future work include developing evidence-based approaches for screening for religious/spiritual concerns and for spiritual

assessment for people with mental illness. Work is also needed to develop and test individual and group spiritual care interventions. Under the auspices of the Transforming Chaplaincy project chaplains are receiving training in research and are eager to develop collaborations with other researchers who are interested in the role of religion/spirituality in mental health and coping with mental illness and in supporting the development of an evidence-based approach to spiritual care.

Excellence in Mental Health Advocacy: Case Studies in the Nongovernmental, Federal, and Legislative Arena

Chair: Amir Arsalan Afkhami, M.D., Ph.D.

Presenters: Suzan Song, M.D., Ph.D., M.P.H., James Lamont Griffith, M.D., Kahlil A. Johnson, M.D., Allen R. Dyer, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to demonstrate how psychiatrists can shape behavioral health policy on the federal, legislative, and local levels; 2) At the conclusion of this session, will be able to demonstrate how psychiatrists can shape federal monitoring of failing correctional institutions; and 3) At the conclusion of this session, the participant will understand the history and current implementation status of the Excellence in Mental Health Act and the Trafficking Victims Protection Act

SUMMARY:

The mentally ill population in the United States has been shown to suffer from increased health problems, mortality, and a variety of social difficulties including higher rates of poverty, incarceration, abuse, and homicide. Psychiatrists can play a vital role in shaping strong behavioral health policies on both the local and national levels to mitigate some of these outcomes. Their vantage point as care providers gives them unique insights on the medical, social, and economic needs of the mentally ill. This panel will look at case studies based on personal engagements in the policy making process to demonstrate how psychiatrists can engage on the legislative, federal, and organizational arenas to shift these negative trends. On the

legislative level, the Excellence in Mental Health and Addiction Act, its formation, 8-state implementation, and the current Excellence Act Expansion will be evaluated. The act was designed to increase access to community mental health and substance use treatment services while improving Medicaid reimbursement for these services. Psychiatrists have a unique role in understanding and managing extreme complex trauma. They also have insights into helping identify exploited persons and engage with federal agencies on the prevention and management of trafficked persons. This panel will shed light on the role of psychiatrists in the implementation of the Trafficking Victims Protection Act and policies on the federal level to mitigate one of the largest criminal activities in the world, second only to drug trafficking. The panel will also look at the role of psychiatrists as drivers of change in the criminal justice system through advocacy and policy making in the federal monitoring of failing correctional institutions where at times between 40-70% of the population have a mental or substance use disorder. The speakers in this session will include psychiatrists who have worked as legislative advisors in the U.S. Senate, advisors to federal agencies including the U.S. Departments of Defense, State, Health and Human Services, and Justice.

Fake Views: Comparing the Royal College of Psychiatrist's Policy Development With the APA—Is There a Special Relationship?

Chair: Wendy Katherine Burn, M.D.

Presenters: James Robert Batterson, M.D., Adrian J. James, M.B., M.Sc., B.S., Kate Lovett

Discussant: Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process for policy development at APA and Royal College of Psychiatrists; 2) Have knowledge of the historical connection between APA and RCPsych; 3) Be aware of the historic and current barriers to full participation of women in the running of APA and RCPsych and how to overcome these barriers; and 4) Be aware of where the organisations of got policy wrong and raise awareness as to how to prevent this happening.

SUMMARY:

The APA and Royal College of Psychiatrists are key organisations in developing and influencing mental health policy. The APA celebrates its 175th anniversary in 2019. The Royal College of Psychiatrists has a history going back to 1841. There have been many examples of collaboration between the organisations particularly around key policy issues. Each has developed quite different systems and processes to develop policy. These will be explored and contrasted with a view to shared learning. There are clear examples of policy which has later been shown to be quite wrong. These will be explored. How do we prevent this in the future? What current policy will be regret in future. Much policy has been developed by men, and women have not been afforded the opportunity for full participation in the life of the organisations and policy development. What have been the barriers and how do we ensure full participation for all groups who have often been marginalised. Women now hold many leadership roles and there is much to now be proud of. What still needs to change.

First-Episode Psychosis in the Criminal Justice System

Chairs: Jamie Spitzer, M.D., Ann L. Hackman, M.D.

Presenters: Maureen Cassady, M.D., Marissa A.

Flaherty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the vulnerabilities of the current system through case studies of first episode psychosis entangled in the legal system.; 2) Highlight the need for further research and consideration of this particular population; 3) Improve workup and treatment for people with first episode psychosis while incarcerated and discuss with audience how to implement and advocate for the appropriate changes.; and 4) Discuss with audience how to implement and advocate for the appropriate changes to reduce rate at which individuals with mental illness are incarcerated or jailed

SUMMARY:

The largest mental health provider in this country is the prison and jail system. In the 2012 Department

of Justice review, 800,000 prisoners (37%) and nearly a million jail inmates (44%) suffered from mental illness. In a review of first-episode admission, 71% had been arrested prior to hospitalization and 58% incarcerated. Individuals with first episode psychosis who are incarcerated have longer periods of untreated psychosis and therefore worse outcomes and prognosis. This becomes their introduction to mental health and likely discourages future engagement for patients and their families. As a resident I watched the fate of parallel young men with a keen ear for music, a passion for superheroes, and a loving mother determined by the officers responding to their mother's 9-1-1 call. One such man engaged with treatment and started medication within days and then him and his mother began their journey with the support of a first episode clinic. The other waited months before starting treatment, received more medications, perceived the treatment as part of his incarceration, and had no opportunity to engage his mother in his treatment. First episode psychosis is a particularly vulnerable population and the treatment offered in this time frame greatly affects the life of the individual suffering as well as the lives of their family. Everyone with first episode psychosis and their families deserve the same opportunities for treatment. To facilitate much needed change and do better by our patients, we must examine historical policy changes, current policies, state to state differences, and case studies to engage in a discussion about advocacy and practical changes we as mental health professionals can lead. This workshop will consider relevant literature, describe and explain approaches in Maryland as well as noteworthy approaches across the country, and with our audience, consider these and other strategies to lead change and better serve those with mental illness to decrease the percent of those with first episode psychosis that enter the forensic system and demand better treatment for those in it.

Fool the Eye, Fool the Mind: The Importance of Vision in Psychiatry

Chair: Saul Levin, M.D., M.P.A.

Presenter: Robert Abel

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the anatomy and physiology of the visual system; 2) Articulate the eye as the window to the body, brain and mind; 3) Recognize the interplay between our dual eyes and dual minds; 4) Learn eye movements are indicators of mental status; and 5) Emphasize the importance of vision in psychiatry

SUMMARY:

The importance of the eye in understanding mental illness has been virtually ignored. The eye provides 80% of our sensory connection to the world. The visual process connects the information that comes from the eye to how we think. I will explore how the mind relies heavily on its headlights in the dark. There will be audience interaction and many clinical examples. There are dual systems at work on both sides of the "Vision Boulevard." There are continuous direct macular and peripheral visions and simultaneously both conscious and unconscious perception. The eye is never truly objective and relies on the orientation and interpretation from the mind. So, when should we trust our instincts or deliberate thoughts? Illusions and sudoku puzzles will illustrate this dilemma. Ocular anatomy, physiology and the multiple components of vision will be elucidated. The routine ophthalmic exam and reliance on an eye chart do not constitute a comprehensive analysis of vision. More information about mental status can be gleaned by merely observing the patient's eyes as humans are the only species with a prominent white sclera. Therefore, lids, brows, pupillary reactions and eye movements serve as indicators of multiple psychiatric disorders. Psychiatrists will learn that our eyes are never still. Fixation is constantly interrupted by saccades, torsions and blinking. Furthermore, we really only see in two dimensions. The mind routinely has to extrapolate incompletions based on previous experience. Dreams, illusions and hallucinations will be explored, as rising from either direction on the "Vision Boulevard." Recent reports confirm the association of ocular disease with neurological disorders since the retina is the extension of the forebrain. Lee et al found consistent associations with Alzheimer's, while Arrigo documented visual system involvement in newly diagnosed Parkinson's patients. Cognitive decline parallels vision loss;

cataract surgery often provides a rapid reversal. Patients with macular degeneration and glaucoma may experience hallucinations. Diagnosis and therapy of eye-mind dysfunction can be supported by both natural and high tech options. Environment, diet, lifestyle, systemic disease, stress and sleep will be identified as major risk factors for both ophthalmic and psychiatric illnesses. Electronic devices such as the OCT, can rapidly detect Parkinson's, Alzheimer's and MS. Natural remedies, such as IV glutathione, may improve patients with Autism, Parkinson's and ALS. Psychiatrists have used eye movement to access the midbrain in PTSD therapy. Knowledge of the eye-mind connection should augment the 21st century psychiatrists' armamentarium. However, the question shall remain as to whether beauty is in the eye or the mind of the beholder. After this presentation, you will know.

From #Metoo to #TimesUP and the Role of Psychiatry

Chair: Jessica A. Gold, M.D., M.S.

Presenters: Theresa M. Miskimen, M.D., Kali D. Cyrus, M.D., M.P.H., Carolyn Bauer Robinowitz, M.D., Carol Ann Bernstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the landscape of sexual assault, harassment and discrimination in medicine, particularly as these issues impact women.; 2) Understand how sexual harassment is related to other gender based inequities in medicine.; 3) Identify additional challenges these present for racial, ethnic, and other identities which intersect amongst sexual minority populations.; 4) Identify potential interventions at the individual and organizational levels.; and 5) Assess the role of the psychiatric community in leading and promoting change in our medical communities.

SUMMARY:

Since the Harvey Weinstein scandal erupted in Hollywood, social media has been flooded with stories using #MeToo to describe personal experiences with sexual assault and harassment. What was clear from the popularity of the conversation, besides its innately validating nature, was just how rampant and pervasive these

experiences are. Medicine was in no way excluded from the conversation. In fact, according to the National Academies of Sciences, Engineering, and Medicine (NASEM) report on sexual harassment of women, as many as 50% of female medical students report experiencing sexual harassment (1). In another study, 30 % of women (as compared to 4% of men) reported experiencing harassment in academic medicine (2). Harassment can occur from colleagues and supervisors, but also from patients and their family members. The impact of sexual harassment on physicians with intersecting, minority identities, such as race, presents additional and complex barriers in a professional setting (3). The NASEM report's conclusions are also consistent with barriers to career advancement (4) and persistent salary gaps in medicine (5). In other words, discriminatory environments can produce abuse of all kinds, with the current spotlight on gender (6). The social media narrative is now moving beyond storytelling and #metoo and towards strategies to intervene and promote change (6) (7) #TimesUP is a "call to action". This forum will explore how psychiatry should be involved and respond to that call.

From Access to Excellence: Creating a Culture of Care Through Telepsychiatry in Community Mental Health Settings

Chair: Mehdi Mahmood Qalbani, M.D.

Presenters: Matthew Weinert-Stein, Steven L. Weinstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to identify challenges to accessing mental health services in underserved settings; 2) At the conclusion of this session, the participant will understand the clinical, technological, and operational components of implementing a telepsychiatry program within a CMHC setting.; 3) At the conclusion of this session, the participant will be able to discuss gaps in care and efforts thus far in a telepsychiatry program, and what might remediate these concerns moving forward; and 4) At the conclusion of this session, the participant will have added to their network of colleagues for collaboration in future projects

SUMMARY:

Access to mental healthcare for low-income patients has become a critical issue in both rural and urban settings throughout the United States. The widespread shortage of physicians, in addition to increasing costs for care has led to a financial and mental health crisis that will continue to deepen if no solutions are found. Telepsychiatry is a part of the solution, and many companies- both private and public- are making a concerted effort to combat this issue and increase access to behavioral health in underserved communities. This presentation will explore such programs by drawing on clinical, technological and operational perspectives, with a specific focus on why such programs are important, how they are implemented, and what components have proven critical to developing a culture of excellence among providers in the face of geographic separation. As there is little formal training in residencies on the use of telepsychiatry and given the diversity of mental health perspectives across discipline and location, participants will first be asked to share challenges they face when providing adequate care to underserved communities. Doing so will establish a context for the importance of establishing a cohesive culture across such programs, and the conversation will be enriched with a review of extant literature and case studies. A special focus will be paid to the unique intersection of medical, technological and operational sectors of a successful program. During this portion of the presentation, criteria for program establishment including clinic and provider vetting, technical and logistical considerations for implementation, and challenges facing the sustainment of such programs will be discussed. We will further examine ways in which best practices as put forth recently by the APA and ATA should be integrated into a care delivery along with region-centric concerns and legal requirements. Finally, strategies for maintaining and building consistency after program establishment, including institutional outreach, clinical remediation and community building will be explored. To conclude, we will discuss what is in store for the future of telepsychiatry, and how we will prioritize their patients and providers moving forward. Time will also be left for open discussion about concerns

regarding clinical quality in telepsychiatry programs. The goal of this portion would be to not only address lingering questions by those considering the merits of such programs, but to also allow participants to discuss how they might address such concerns about telepsychiatry programs in their own clinical contexts.

From Confinement to Chemicals: What We Can Learn From Following the Management of Agitation Through History

Chair: Anita Kumar Chang, D.O.

Presenters: Ashika Bains, M.D., Pedro A. Bauza, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the origins for the use of medications dating back to the first biologicals used in medicine to treat agitation associated with mental illness; 2) Evaluate what works and what continues to be problematic in how we currently manage agitation; and 3) Provide future directions for how we can manage agitation knowing where we have come from historically in this field

SUMMARY:

The institutionalization of the mentally ill dates back to before the United States even declared its independence. The treatment of the mentally ill in such institutions devolved into chaos and mass maltreatment. So much so that even now efforts to manage patients, either by treating their illnesses or by trying to manage their behavior, are largely considered inhumane in the public eye. In this general session, the history of agitation management in America will be outlined and discussed through an evaluation of the scientific literature, historical and modern first person accounts, and media portrayals. Understanding the past can add a degree of clarity to present guidelines. For example, the now highly regulated use of restraints can be traced back to misuse over much of psychiatric practices' history. And the origin of the use of 'tranquilizers' or 'chemical restraints' can be seen as connected to the first biologicals used to attempt to treat mental illness. By acknowledging the historical roots of our management we can candidly turn to the future and guide our practices for the betterment of our patients. Our session will

review the history of the management of agitation in America using diverse mediums, from quotes to sketches to photography to audio and video excerpts from the various multi-media sources mentioned above. We will stimulate conversation and analysis through small group breakout sessions interspersed between the lecture portions of the session.

From Genetics to Stress Response to Treatment of Personality Disorders

Chairs: James Harry Reich, M.D., Maria Mercedes Perez-Rodriguez, M.D., Ph.D.

Presenters: Emil Frank Coccaro, M.D., Barbara Stanley, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain knowledge of genetic and peripheral markers of aggression and how they may have clinical relevance.; 2) Understand the unique stress response in borderline personality disorder and how this may relate to suicide.; and 3) Learn techniques for the non-personality disorder expert clinician to approach the treatment of personality pathology.

SUMMARY:

The development of personality pathology is a complex process. As with much other human behavior some predisposition develops due to genetics. Aggression in patients is an important clinical problem. Our first presentation will discuss research on the genetics of aggression using clinical examples to highlight the research findings. Any clinician who has worked with borderline personality disorder recognizes the challenges that entails. One of these challenges is the exquisitely sensitive response to stress that these patients may exhibit. Our second speaker will present clinically useful research on the borderline personality disorders stress response syndrome. Clinical examples will help bridge the research and clinical domains. The third presentation will examine the treatment of personality disorder for the average clinician. Topics covered will be personality pathology in the clinical population, comorbidity with syndrome disorders, a discussion of validated approaches to personality disorder treatment and what these findings mean for the clinician. Overall we hope the combinations

of presentations will challenge the participants to think of how they can improve the treatment of personality pathology in their own patients.

From Pipeline to Prescription Pad: An FDA Primer on Psychiatric Drug Approvals and Safety Part 1 (IND Process, Labeling, and Safety Reporting)

Chair: Jean Kim, M.D.

Presenters: Juliette Toure, Pharm.D., M.B.A., Kim Updegraff, Pharm.D., Javier A. Muniz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the phases of the drug development regulatory process and how an Investigational New Drug (IND) gets considered for New Drug Application (NDA) approval; 2) Hear about Breakthrough, Fast-Track, and data collection grant initiatives to encourage innovative drug research and development; 3) Describe the regulatory process behind drug labeling and what information is being conveyed to prescribers and why; and 4) Learn about postmarket safety reporting and how you and your patients' voices on clinical experience with a drug can matter

SUMMARY:

This session will orient psychiatrists to the drug approval and safety monitoring processes of the FDA. We will provide an overview of the two main regulatory pathways for psychiatric drug development: research (academic) and commercial (industry). We will go over the four main phases of drug development and how the Division of Psychiatry Products regulates each phase. We will discuss the initial IND application for a first-in-human Phase 1 study of a new molecule (typically after extensive nonclinical evaluation), trial design considerations for proof-of-concept Phase 2 studies for a treatment indication, and the standards for efficacy and safety for Phase 3 studies for potential drug approval via NDA review (more details on Phase 3 will be provided in Part 2). We will go over special regulatory pathways to encourage innovative programs such as Fast-track and Breakthrough Therapy designations. The next presentation will discuss our rationale behind drug labeling policies and the important prescribing and safety information found in each section. We will discuss

some of the latest updates on label formatting, such as the Pregnancy, Labeling, and Lactation Rule (PLLR) section. Finally, we will discuss Phase 4 postmarketing study considerations and postmarket safety reporting (via the FAERS reporting system), where your voice as a clinician is extremely influential to the process.

From Pipeline to Prescription Pad: An FDA Primer on Psychiatric Drug Approvals and Safety Part 2 (NDA Benefit-Risk Assessment and REMS Planning)

Chair: Jean Kim, M.D.

Presenters: Michael Charles Davis, M.D., Ph.D., Bernard A. Fischer, M.D., Nancy Dickinson, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the Benefit-Risk Assessment applied to each NDA for potential market approval based on efficacy and safety; 2) Review case examples of applications of the Benefit-Risk Assessment for drug approval; 3) Learn about Risk Evaluation and Mitigation Strategy (REMS) planning and implementation; and 4) Discuss the case example of clozapine and ongoing updates to the clozapine REMS

SUMMARY:

This session continues an in-depth orientation to the review process and thinking behind psychiatric drug approvals at the FDA. After conducting Phase 3 clinical trials and deciding that a drug has shown potential efficacy and safety for a given treatment indication, a drug sponsor will send in a New Drug Application (NDA) package for review. This package usually consists of detailed efficacy and safety information about the clinical trials they are citing to support the NDA, and relevant information from earlier drug development phases as well. The cornerstone of our evaluation process is the Benefit-Risk Assessment, in which we weigh the proposed benefits of a drug against its risks and decide whether, for a given treatment indication and population, this drug should be approved. We will cover several in-depth examples of prior approved drugs to demonstrate this review process. Another significant regulatory process to mitigate safety concerns and benefit-risk balance is the implementation of a REMS (Risk Evaluation

Mitigation Strategy) program, where marked prescribing restrictions (i.e., “elements to assure safe use”) are mandated for a drug with significant safety concerns, but important potential benefit for a specific population. One well-known example of a drug under a REMS is clozapine. We will discuss the history of the clozapine REMS, its implementation, and the rationale for recent updates to the clozapine REMS program.

Gun! A Simulated Encounter With an Armed and Agitated Patient

Chair: Alexander C. L. Lerman, M.D.

Presenters: Hameed Azeb Shahul, M.B.B.S., Muhammad Anas Farooqi, M.B.B.S., Jasra Ali Bhat, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify firearms as objects with physical risk and charged psychological significance, for both clinician and patient.; 2) Discuss the impact of a mental health clinician’s attitudes and preconceptions about firearms on the assessment of a firearm-possessing patient.; 3) Demonstrate how to integrate a “firearms history and review of systems” into a comprehensive biopsychosocial formulation.; 4) Identify the psychological dynamics and range of possible responses to the armed psychiatric patient; and 5) Identify and demonstrate how awareness of the psychiatric aspects of firearm possession translate into high-value interview techniques

SUMMARY:

The assessment of firearms possession, including the prospect of an encounter with a patient who is armed, represents an expanding, troubling frontier in the practice of psychiatry. In this workshop, we will examine the unique challenges associated with such assessment, including a potentially lethal potential to safety; unfamiliarity and discomfort with firearms among many clinicians, and the lack of clear guidelines regarding firearm-related incidents. A patient presenting in a clinician’s office in possession of a firearm represents a unique problem, not least due to the intense anxiety that such a development generates in the clinician. In the interview setting, assessment of weapon possession hinges on such

factors as the patient's reality testing, affective state, and stated reasons for carrying a firearm, including individuals who have what would generally be regarded as legitimate reasons to be armed. An interviewer should attempt to be calm, friendly, and non-threatening, and select an appropriate clinical option based on their assessment. Assessment is complicated by the fact that patients whose firearm ownership is of the highest concern are likely to be the least forthcoming regarding it during a clinical interview. Individuals who are paranoid, engaged in substance abuse or criminal activity, or actively suicidal, all have strong motivations to minimize or conceal firearm ownership. We developed a training exercise designed around the following simulated patient scenario. "Gary is a corrections officer and military veteran brought in for evaluation after he was found drinking beer in his car with a handgun nearby. He insists that he had no intention of hurting himself or anyone else. He minimizes the significance of his experiences in combat, but acknowledges a range of psychosocial problems. In the later course of the interview, "Gary" has a panic attack and pulls up his shirt to wipe his face, revealing a realistic toy handgun in his waistband. A preliminary review of 31 interviews shows a wide range of responses among interviewers: 30% of interviewers fled the interview room with no explanation to the patient, only 21% of residents asked "Gary" to surrender or secure his weapon and continued the psychiatric interview after he had done so, and 22% established a history of previously-undiagnosed PTSD. Interviewers who displayed the best clinical management during the simulation were more likely to demonstrate "empathy" and "warmth" during the clinical interview, and to engage in "confrontation" of discordant data. These results suggest that greater attunement by the clinician to the patient's psychological state during the interview is associated with a better estimation of risk, and a greater range of options as the encounter unfolds.

Gymnasts, Musicians, Alter-Boys; After 50 Years of Child Abuse Laws, What's Missing?

Chair: Lenore C. Terr, M.D.

Presenter: Jon Eisenberg

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the 50-years olds laws as they were set, in part, through psychiatric input about childhood trauma; 2) Form opinions regarding whether suspicions of abuses on those between 18 and 21 by people in power should be mandated to be passed on to legally designated authorities; 3) Communicate to teachers' unions, school systems, medical institutions, etc. that records must be permanently retained because perpetration is habitual and rarely treatable; and 4) Consider whether religious institutions can be allowed to use "privilege" to fail to report to civil authorities or to make internal records unavailable

SUMMARY:

Fifty years ago mental health practitioners helped draft state and federal laws requiring medical reporting to police and social agencies whenever child abuse was suspected. In time, mandated reporters came to include educators, camp counselors, child-care workers, even photo developers. The laws were successful in safeguarding numbers of children, saving lives, and in some cases providing helpful treatment. There would be no doctor-patient privilege in cases of suspected child abuse. Within a few years, as well, legal adulthood – as established by American voting eligibility – would be age 18., which might be assumed as "the end of childhood." However, no matter how effective the laws have been, mental health clinicians are becoming increasingly concerned about three issues not apparently covered by a half-century of legislation. These are: (1) abuses of late adolescent (age 18-21) athletes, musicians, and others by those with the power to cause them to fail in their chosen field; (2) destruction of records having to do with complaints about perpetrators; (3) use of "religious privilege" to protect religious leaders and records from being exposed. This session will address the present state of affairs in the child abuse field by presentation and discussion. One of us, a child/adolescent psychiatrist and trauma researcher, will share cases of each of the three problems cited above. The testimonies of girl gymnasts at L. Nassar's sentencing hearing will be discussed in this context. One of us, a California appellate attorney, will present what lawyers, legislators, and policymakers have been considering regarding these

matters. Session participants will be asked – in each of the three problem instances - for their input. Ideas for solutions will be welcomed and discussed.

Health Promotion in the Military: Engaging Communities to Promote Behavioral Health

Chairs: Daniel R. May, D.O., Connie Thomas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Compare and contrast health promotion processes between different branches of the Military; 2) Discuss the composition of health promotion platforms, including roles and responsibilities, trend analysis and recommendations for allocation of resources; 3) Review examples of how eliciting involvement from community leadership leads to improvements in systems of care; 4) Discuss the importance of maintaining patient confidentiality while maintaining a patient centered mindset; and 5) Identify future applications of health promotion within the Military and potential implications outside of the Military

SUMMARY:

Health promotion in the military is an important practice for developing a shared understanding between military leaders, clinicians and other support agencies. While attempts at standardizing the health promotion process have been effective in the different branches of the military, there is much variability and room for sharing best practices between the branches. This presentation will review these policies and practices from a psychiatric perspective from representatives from the different branches of the military. Participants in health promotion platforms have a shared interest in ensuring the optimal health of Service Members. Health promotion platforms can be effective in both improving prevention efforts as well as improving existing systems of care. The complex biological, psychological and social needs of patients and communities requires a multidisciplinary approach which engages all levels of leadership and subject matter expertise. These platforms offer an opportunity for clinicians to communicate observed clinical trends to military leadership to effect change to systems of care. These health promotion platforms also include participation from nonclinical

experts that bring financial, legal, policy, and other perspectives in alignment with the commander's guidance in a rapidly changing military environment. Given the wide audience, it is important to ensure patient confidentiality while also communicating the needs of patients.

Help APA Build the Meeting of the Future: An Interactive Town Hall Looking at IPS: The Mental Health Services Conference in 2021 and Beyond

Moderators: Anita Everett, M.D., Glenn Laudenslager, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the key topics for inclusion in a mental health services conference; 2) Define key participant groups for participation in a mental health services conference; and 3) Rank factors within a meeting that are most likely to translate into the provision of better health care to patients

SUMMARY:

APA is currently redesigning APA's fall meeting, IPS: The Mental Health Service Conference (IPS), and needs your input. Using interactive audience response technology and a professional facilitator, come share your ideas and suggestions for ways to revamp, reshape, and enhance the IPS conference. This session is open to APA members and non-members and will focus on questions related to meeting format, interactivity, content, and networking. Attendees are encouraged to bring their smartphones or other mobile device to fully engage in the discussion. Join us in shaping the future of IPS.

Helping Clinicians and Patients Harness the Power of Exposure-Based Treatments

Chair: Robert D. Friedberg, Ph.D.

Presenters: Colleen Harker, Jennifer Park, Jeremy Peterman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the knowledge, skill, and attitudinal variables that compromise clinicians' use of exposure-based treatments; 2) Recognize the three foci (didactic, experiential, self-reflective)

involved in clinical training; 3) Acquire pedagogical strategies for teaching exposure-based treatments; 4) Learn supervisory techniques aimed at increasing trainees' technical proficiency; and 5) Obtain skills to modify trainees' inaccurate attitudinal biases toward exposure

SUMMARY:

Exposure-based treatment is an active and central component of effective psychotherapy for anxiety disorders. However, despite robust empirical support, many practicing clinicians do not correctly implement exposure therapies. Multiple investigators have found that fewer than 30 percent of clinicians report implementing exposure-based procedures. This finding supports the contention that exposure-based treatments are one of the least used yet most effective treatment options for anxious youth. Consequently, vulnerable young patients do not receive proper care. Insufficient didactic training, inadequate supervision/organizational support, and clinicians' mischaracterizations about exposure-based treatment all contribute to clinicians' reluctance to deliver these procedures. This session brings together four experts in exposure therapies for pediatric patients to address barriers to implementation across diverse clinical contexts and recommend strategies for obviating these obstacles. The presentation will begin with a brief overview of three essential domains in clinical training: didactic knowledge, experiential learning, and self-reflection. Panelists will then discuss barriers to building a knowledge base which supports the use of exposure techniques. Pioneering recommendations to mitigate these obstacles will be suggested. Inventive ways to present the theoretical rationale underlying these exposure-based treatments and the rubrics governing the application of specific exposure techniques will also be delineated. The session will then turn to clinical supervision issues. The panelists will propose advanced supervisory processes to build technical proficiency, with an emphasis on experiential learning. These strategies will include supervisor modeling, co-therapy, and live supervision models. Next, various misconceptions about exposure (e.g. exposure causes harm, worsens symptomology, increases attrition, enhances the risk of malpractice litigation, requires lengthy sessions,

and exceeds young patients capacities) will be debunked. Multiple supervisory approaches aimed at mitigating these attitudinal biases including cognitive restructuring and behavioral experiments will be discussed. Finally, attendees will learn "fun" ways to implement exposures. Consistent with the themes of the 2019 convention, this proposal serves revitalization, innovation, inclusiveness, and engagement to propel greater implementation of exposure-based treatment. The supervisory techniques discussed revitalize training. State-of-the-art procedures for attenuating knowledge gaps, skills deficits, and attitudinal biases supply necessary innovations. Appealing and contextually relevant training strategies nurture inclusiveness and engagement. Attendees will leave the session with skills that will help them harness the power of exposure and increase their trainees' competence in delivering this gold standard treatment. Case examples will augment the discussion.

Highs and Lows: Clinical Pearls and Lessons Learned in the Outpatient Management of Geriatric Bipolar Disorder

Chair: Erica C. Garcia-Pittman, M.D.

Presenters: Thu Anh Tran, M.D., Tawny Smith, Victor Manuel Gonzalez, M.D., Alexandria Harrison

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the pharmacologic management of bipolar disorder in patients with comorbid Parkinson's disease.; 2) Discuss the complications of Bipolar symptoms associated with the pharmacologic agents used to treat Parkinson's disease.; 3) Review the use of mood stabilizers in geriatric patient with bipolar disorder and an emerging major neurocognitive disorder; and 4) Explore and discuss cases of subtle toxicity from mood stabilizers in the geriatric population

SUMMARY:

This session will highlight several challenging and complicated cases of geriatric bipolar disorder treated in an interdisciplinary geriatric outpatient clinic. We will share our lessons learned from these clinical encounters with the assistance of a clinical psychiatric pharmacist. We will review management of traditional mood stabilizers and associated

symptoms of subtle toxicity related in the context of medical co-morbidity and aging. Additionally, we will highlight the difficulties of managing a patient with newly diagnosed Parkinson's disease. Lastly, we will review a case of neurocognitive decline concerning for a major neurocognitive disorder in a patient with longstanding bipolar disorder. Our clinical psychiatric pharmacist discussant will review clinical pearls related to each of the cases presented. Additionally, we will share knowledge regarding literature updates, as well as guidelines for treatment of the aging patient with bipolar disorder. Individual Abstracts: Gonzalez: This session will highlight several challenging and complicated cases of bipolar disorder treated in an interprofessional geriatric outpatient clinic. Dr. Gonzalez will discuss the pharmacologic management of bipolar disorder in patients with co-morbid Parkinson's disease. Specifically, he will highlight the challenges of using medications that can have a paradoxical effect on mood and/or movement symptoms. Harrison: This session will highlight several challenging and complicated cases of bipolar disorder treated in an interprofessional geriatric outpatient clinic. Dr. Harrison will discuss cases of geriatric patients with bipolar disorder who are managed on traditional mood stabilizers. She will go on discuss how these cases were complicated by the development of toxicity and the subtle signs of toxicity in this population. Tran: This session will highlight several challenging and complicated cases of bipolar disorder treated in an interprofessional geriatric outpatient clinic. Dr. Tran will discuss a case of a patient with bipolar disorder who developed a neurocognitive disorder. She will review the clinical pearls and challenges of managing this complicated patient. Smith: This session will highlight several challenging and complicated cases of bipolar disorder treated in an interprofessional geriatric outpatient clinic. Dr. Smith will serve as the discussant. She will use her clinical pharmacy expertise to review key clinical pearls related to each of the cases presented. Additionally she will share knowledge regarding literature updates as well as guidelines for treatment of the aging patient with bipolar disorder.

History, Aging, Discrimination and Impairment

Chair: John S. McIntyre, M.D.

Presenters: Dilip V. Jeste, M.D., Nada Logan Stotland, M.D., M.P.H., Roger Peele, M.D., Farooq Mohyuddin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe strategies of successful aging among psychiatrists; 2) Understand harassment of and discrimination of women; 3) Understand the implications of key federal cases including Durham, Rouse v Cameron and Lake v Cameron; and 4) Better understand the means to identify and report impairment in colleagues

SUMMARY:

This symposium is sponsored by the Senior Psychiatrists. The first presentation (Dilip Jeste) will review the research that provides convincing evidence of brain plasticity with aging in people who keep themselves active physically, cognitively, and socially. A number of empirical studies have demonstrated that positive factors such as resilience, optimism, wisdom and social support are associated with better physical and mental health and even longevity, with effect sizes that parallel or exceed those of pharmacological interventions. Physicians in general, and psychiatrists in particular, have unique opportunities to enhance their own psycho-bio-social functioning in later life while also contributing to the society's well-being. This presentation will discuss specific strategies of successful aging among psychiatrists. The second presentation (Nada Stotland) will describe Dr. Stotland's personal experience as one of five women in a medical student class of seventy-two. Dr. Stotland will point out that there has been enormous changes in women's rights and opportunities since that time but we must not let those advances blind us to the persistent harassment, abuse and discrimination suffered by women (and members of minority groups,) ranging from subtle to femicidal, and their impact on our trainees, colleagues, and patients. The third presentation (Roger Peele) reviews the history of Saint Elizabeth's hospital in Washington D.C. on a site selected by Dorothea Dix in 1852. One of the first admissions to St. Elizabeth's was Richard Lawrence who attempted to kill President Jackson. This iconic institution, which had a peak of 7,460

patients in 1947, has been the focus of substantial legal initiatives including Durham, a decision that an insanity defense should be based on whether the crime was the product of a mental illness, and a number of right to treatment decisions and right to least restrictive treatment. The presentation will include the details of a phone call from President Regan to Roger Peele, in which President Regan asked Dr. Peele if he (Regan) should pardon John Hinckley. The audience will be encouraged to participate in the discussion of this question. The fourth presentation (Jack McIntyre) will focus on state Physician Health Programs, which monitor physicians who are impaired, generally by use of alcohol and/or drugs or by mental illness. Details will be shared from the NY Physician Health Program, which currently monitors approximately 500 physicians. Dr. McIntyre chaired the NY PHP for ten years. This presentation will also recommend when physicians should report physicians who may be impaired and how to do this.

Impact of Marijuana on Opioid Use and Pain: A Translational Overview

Chair: Carlos Blanco-Jerez, M.D., Ph.D.

Presenters: Ziva Cooper, Ph.D., Rosanna Smart, Mark Ilgen, Ph.D., John J. Mariani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Examine the analgesic properties of cannabinoids; 2) Examine the effects of cannabis policy on opioid use; and 3) Discuss the potential of cannabis and cannabinoids to decrease clinical use of opioids

SUMMARY:

This session will discuss whether marijuana should be employed as a strategy to combat the ongoing opioid crisis. The session speakers will discuss their research on the intersection of marijuana, opioids, and pain, encompassing human clinical laboratory work, epidemiological studies, policy analyses and clinical interventions. Dr. Cooper will discuss the observed efficacy of cannabinoids in a human clinical model of pain. Pacula will discuss her findings of the impacts of marijuana policy on opioid use and outcomes. Dr. Ilgen will provide insights from his work on treating co-occurring chronic pain and

addiction. Dr. Mariani will act as a discussant and will help integrate the presentations with clinical practice.

Implications of Understanding the Mechanism of Action of Ketamine

Chair: Alan F. Schatzberg, M.D.

Presenters: D. Jeffrey Newport, M.D., Gerard Sanacora, M.D., Ph.D., Carolyn Rodriguez, M.D., Ph.D., Nolan Williams, Boris Heifets

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To present recent data on the mechanism of action (MoA) of ketamine; 2) Clinical implications of applying MoA data on ketamine; 3) Review recent efficacy data on ketamine in depression; 4) Present data on ketamine in OCD; and 5) Discuss the risk of continued ketamine use vis-vis tolerance

SUMMARY:

There has been considerable excitement re the potential of a glutamatergic anesthetic agent, ketamine, to rapidly improve depressive symptoms when given intravenously. The putative mechanism of action (NMDA antagonism) has suggested that the drug may be safer to use over time and a number of ketamine clinics have popped up around the country. What is often overlooked is that ketamine acts on opioid receptors and very recent data has demonstrated that indeed the antidepressant effect of ketamine is likely due to its mu opioid receptor binding. This finding raises serious questions re the risks of repetitive and frequent use. Indeed ketamine is a drug of abuse, particularly when snorted but also potentially opportunities for harnessing these acute effects in specific situations. This symposium will present recent data on ketamine with a particular emphasis on the longer term use and on the clinical implications of its acting via mu opioid agonism. The format will be 4 presentations with Q and A. Jeff Newport will review his recent meta-analysis on the efficacy of ketamine in depression, including the durability of response. He will also discuss recent treatment guidelines on the use of ketamine including the limited data on long-term use. Gerard Sanacora will review data on the mechanism of action of ketamine with particular emphasis on

agonism at the AMPA glutamate receptor, secondary to NMDA antagonism. Carolyn Rodriguez will review her pilot neuroimaging studies that explore putative MoA of ketamine in OCD. Nolan Williams will present the very recent data on a study in which the opioid mechanism of action for ketamine was explored a double-blind, crossover study in which patients received 2 infusions of ketamine a month apart. In one they received naltrexone 45 minutes before the infusion or placebo. Data indicate that naltrexone blocked the acute and dramatic effects of ketamine. These data point to ketamine acting on mu opioid receptors either directly or indirectly. Boris Heifets, an anesthesiologist will discuss a strategy to use ketamine preoperatively to reduce the risk of developing opiate use disorder (OUD) post-surgery. Data are presented that comorbidity of depression with knee pain is a risk factor for developing OUD.

Improving Patient Safety on Inpatient Units and the Impact of Recent Changes in Survey Standards by the Centers for Medicare and Medicaid Services

Chair: Grayson Swayze Norquist, M.D.

Presenters: Bruce Jan Schwartz, M.D., Kenneth Michael Certa, M.D., Mark Pelletier, M.S., R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to describe current efforts to improve patient safety and reduce suicide on inpatient facilities.; 2) At the conclusion of this session, the participant will be able to demonstrate knowledge of the new Joint Commission survey standards.; 3) At the conclusion of this session, the participant will be able to provide an overview of the effects of these changes on inpatient psychiatric facilities.; and 4) At the conclusion of this session, the participant will be able to describe the opportunities to improve survey standards and improve patient safety.

SUMMARY:

During 2017 the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) announced an effort to enhance patient safety and reduce inpatient suicides. This led to an increased emphasis on the monitoring of ligature-point and

other self-harm risks during each entity's onsite surveys. This session will present an overview of current knowledge regarding ways to improve patient safety and reduce survey standards and changes that have been implemented since 2017 as well as results of an APA survey on the impact of changes on inpatient services and patient access. The session will provide a report on the perspective of the Joint Commission as well as an inpatient facility's experience with the changes in the survey standards. The session will provide an opportunity to outline potential collaborative opportunities among the APA, psychiatric facilities and The Joint Commission to improve patient safety monitoring while reducing unintended consequences.

Influence of Mainstream Social Media and Social Movements on Mental Health Issues

Chair: Tessy M. Korah, M.D.

Presenters: Kim Christopher Knudson, D.O., Ashley Bindshedler, D.O., Tian Sui, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize how the impact that today's digital world has influenced the stigma surrounding mental health issues; 2) Understand the challenges that individuals experience when dealing with media coverage of violence towards self and others; 3) Analyze how positive social influences, such as the MeToo movement, can increase awareness of trauma and help promote emotional recovery and wellbeing; and 4) Evaluate ways that mental health providers can better promote mental health resilience amidst the massive changes in mainstream media and social movements

SUMMARY:

In today's digital world, thousands of search results can instantly be generated from countless resources via a few strokes on a computer or smartphone. Social media has become primary means of communication across the globe, overcoming both national and language boundaries. As such, local news stories now have the means to reach millions of people across the world each day with relative ease. Historically, media coverage in the United States has placed a negative slant on mental health topics, mainly highlighting stories of violence

towards others as well as self-directed violence. The mainstream social media's obsession for shock value has led to an explosion in coverage that further stigmatizes mental health issues. Less than fifteen percent of mental health stories focus on recovery from mental health issues. There have been a growing number of stories covered in the news appertaining to violent acts committed towards others, primarily in the form of mass shootings. Self-directed violence such as the recent suicides of two major celebrities, Anthony Bourdain and Kate Spade, have appeared in headline news. Despite the historical negativity, the millennial social #MeToo movement, may have opened a renewed focus on mental health issues. It brings to light not only awareness of sexual trauma but also provides support and promotes healing. The mental health impact that these events have had on individuals and society at large, need to be discussed. In our session, we will discuss two case reports of patients who were influenced by these celebrities' completed suicides. The first, a 24-year-old female college student with a history of depression presented with a copycat suicide attempt via hanging approximately one week after Kate Spade's suicide; and the second, a 52-year-old male chef with a history of chronic suicidality presenting for inpatient admission after being influenced by the suicide of Anthony Bourdain. We will also highlight several recent mass shootings, and the influence these events have generally had on the mental health of individuals across the country. We will discuss the positive influence of the #MeToo Movement, which has shed light on the magnitude of sexual harassment and their heavy toll on mental wellness and emotional recovery. The profound impact of this movement also generated successful GoFundMe campaigns designed to provide financial support to men and women who want to bring their personal stories of harassment directly to the justice system. The focus of our discussion will be centered on how mental health providers can become more aware of how the social media influences our patients in both negative and positive ways. We will discuss methods to promote mental health resilience amidst tragedy and provide a call to action for using the power of social media and social movements to empower social justice through mental health awareness and abuse prevention strategies.

Interactive Training and Dissemination of Tobacco Cessation in Psychiatry: An Rx for Change

Chair: Smita Das, M.D., Ph.D., M.P.H.

Presenters: Andrew John Saxon, M.D., Douglas Michael Ziedonis, M.D., Timothy W. Fong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the relevance and importance of tobacco cessation treatment in psychiatric settings.; 2) Review smoking+mental illness epidemiology, medication interactions, nicotine, dual diagnosis and withdrawal symptoms.; 3) Learn and demonstrate brief skills for clinicians using behavioral techniques for smoking cessation, including the 5 A's and pharmacologic cessation aids.; 4) Access RxforChange, a free web based curriculum to disseminate tobacco treatment training for health care professionals, including specific training for psychiatric settings.; and 5) Ask questions of tobacco use disorders experts in real time and post-training.

SUMMARY:

Smoking and smoking related mortality/morbidity continue to disproportionately affect those with mental illness. Among individuals with mental illness, smoking prevalence is 2 to 4 times that of the general population. Smokers with mental illness and addictive disorders purchase nearly half of cigarettes sold in the United States. Smoking is important to psychiatric practice for a variety of reasons such as use or withdrawal effects on behavior/mood, association with future suicide attempts and psychotropic drug level changes. Treating smoking is one of the most important activities a clinician can do in terms of lives saved, quality of life, and cost efficacy. The APA recommends that psychiatrists assess the smoking status of all patients, including readiness to quit, level of nicotine dependence, previous quit history, and provide explicit advice to motivate patients to stop smoking. In the last national AAMC survey of physicians, psychiatrists, as compared to other doctors, were least likely to participate in cessation activities and most likely to feel that there were greater priorities in care and that smoking cessation would worsen other symptoms. Only half of US psychiatry residency

programs provide training for treating tobacco while 89% of program directors have interest in a model tobacco treatment training curriculum. "Rx For Change" is a mental health focused tobacco treatment training program informed by a comprehensive literature review, consultation with an expert advisory group, interviews with psychiatry residency training faculty, and focus groups with psychiatry residents. Rx for Change emphasizes a Transtheoretical Model of change-stage tailored approach with other evidence-based tobacco treatments such as are nicotine replacement, bupropion, varenicline, and psychosocial therapies (integrating 5 A's-to ask all patients about tobacco use, advise to quit, assess readiness, assist, and arrange follow-up). The 4 hour training when included in curriculum for psychiatry residents is associated with improvements in knowledge, attitudes, confidence, and counseling behaviors. This workshop will offer abbreviated psychiatry focused tobacco cessation training with a secondary goal to provide a resource to attendees to use at their sites. Rx for Change is available online via <http://rxforchange.ucsf.edu> at no cost and offers a packaged training tool for improving treatment of tobacco use in psychiatric care. After the training participants receive material from the website that can be accessed later. An expert panel will close the session with an interactive question and answer opportunity. We hope that APA attendees who participate in the workshop, as leaders at their institution, disseminate the training. Dissemination of an evidence-based tobacco treatment curriculum has the potential of dramatically increasing the proportion of smokers with mental illness who receive assistance with quitting.

Invisible Colleges and Virtual Departments: Getting by With a Little Help From Your Friends

*Chairs: Josepha A. Cheong, M.D., John Luo, M.D.
Presenters: Iqbal "Ike" Ahmed, M.D., Marcia L. Verduin, M.D., Robert Joseph Boland, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to identify the origins of the concept of the invisible college; 2) The participant will be able to develop a plan to recruit members of a virtual department; and

3) The participant will be able to identify the barriers that face academic faculty in developing careers

SUMMARY:

In the current climate of increasing clinical demands, decreasing resources, and increasing workload, the development of a career in academic medicine - whether education, administration, or research-based has become an increasingly challenging endeavor. As awareness of physician burnout and the necessity of workplace wellness have become more prominently discussed in academic centers, another important factor of successful faculty development is the need to develop a supportive environment of colleagues. Throughout history, the development of the scientific fields is through the development of scientific communities. One such community is referred to as an "invisible college" - an informal association of like-minded scientists that would be supportive and encouraging of each other to advance knowledge and the field. This is thought to be the earliest form of the more formal Royal Society. In the mid-60 and 70s, historians and social scientists further discussed this concept of invisible colleges as a significant part of not only the development of the individual careers but of the field itself. In contemporary academic medicine, faculty development is a key element of a successful department and institution. Faculty development programs vary from institution to institution and, at times, individual faculty may not easily engage at their own site due to a number of different factors. This session will focus on the development of invisible colleges and the potential impact on faculty development. The value of these "virtual departments" for both individuals and the field will be explored. Through a series of engagement activities, participants will be able to identify and/or develop their own virtual department for personal and professional development.

Joint WPA-APA Council on International Psychiatry Presentation: Psychiatry's Emerging Role in Responding to Emergencies and Adversity

*Chairs: Helen E. Herrman, M.D., M.B.B.S., Gabriel Obukohwo Ivbijaro, M.D.
Presenters: Paul Summergrad, M.D., Afzal Javed, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the high mental health burden, in both standard and emergency settings, in low, middle, and high income countries; 2) Summarize options for pilot and community-based interventions to improve mental health outcomes in emergency and adverse circumstances; and 3) Explain the role of national and international professional organizations, using WPA, APA, and WFMH as examples, in addressing global challenges arising from adversity and emergency situations

SUMMARY:

The World Psychiatric Association (WPA) and American Psychiatric Association (APA) are working to strengthen the contribution of psychiatrists as partners in regional and national responses to conflicts, emergencies, and adversity. These activities include training psychiatrists and other clinicians in emergency psychiatry interventions and preparing them for their roles as partners in working with communities, publishing guidelines and best practices, and working with non-governmental organizations to highlight the need for greater attention to the mental health consequences of adversity and emergencies. WPA has established a partnership with citiesRISE to demonstrate the role of psychiatrists and mental health professionals in improving the mental health of young women and young men living in adversity. These efforts will occur initially in five cities worldwide, including two in the US. The roles of APA and WPA in advocating for mental health goals to be included in the UN Sustainable Development Goals will be highlighted, as will workforce challenges, integration with primary care, working with communities, and need for increased preparation in addressing the global increase in health care burden due to non-communicable diseases (NCD's), including mental health disorders. Mental health advocacy is important and the voice of patients will also be considered. Presenters will include the President and President-elect of WPA, a past president of APA, and a past president of the World Federation for Mental Health (WFMH). Time will be allotted for large group discussion, dialogue, and questions.

Leadership and the Changing Mental Health Landscape

Chair: Jacqueline M. Feldman, M.D.

Presenter: Barbara Van Dahlen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to articulate a clear understanding of the dynamics that create a fluid national and international landscape that requires innovation.; 2) At the conclusion of this session, the participant will be able to identify opportunities to use their skills and expertise to address individual and systemic needs in a changing landscape.; and 3) At the conclusion of this session, the participant will be able to identify critical leadership characteristics and skills that will allow them to serve new populations and communities.

SUMMARY:

Leaders in the US and around the world are becoming more focused on the need to address mental health challenges and mental illness through new approaches and strategies. Concerted efforts to raise awareness and remove cultural barriers to care seem to be gaining momentum in both developed and underdeveloped countries. In 2018, London hosted the first Global Ministerial level Summit on Mental Health ever held - with a second gathering already planned for 2019 in the Netherlands. Corporations are creating wellness programs for employees as they too recognize the staggering cost of unaddressed mental health issues within their workforce. Universities - like UCLA with its Grand Depression Challenge - have created programs or adopted initiatives to reach students who are struggling. While these are positive developments, there is much work that remains to be done. As we know, the vast majority of those who struggle with poor mental health fail to seek or receive the care and support they need. Most individuals lack basic language to explain their psychological states and most have little understanding of the progression of mental illnesses that may appear in their family histories. Few people understand how to access care in their communities. And sadly, for many here in the US and around the world, care is not readily available. As a result, those affected by mental

health challenges often fail to engage in preventive efforts. They are not proactive in addressing their challenges because they are not raised to understand them. They do not seek early interventions and they often attempt to hide their struggles. Stigma continues to be a major factor that contributes to poor care. Indeed, most of us try to push through emotional pain and psychological suffering ignoring early indicators that may be signs of serious mental health conditions that could actually be treated. Psychiatrists have unique skills and abilities that are sorely needed as we work across communities, sectors and borders. For example, technological advances have provided opportunities and yet, as is often the case, tools are developing faster than we in the profession can assess and advise those who might look to them for solutions and relief. Psychiatrists have the knowledge and the opportunities to consult, advise and assist those who are hurting - and those individuals and organizations who serve them. But in order to do this, we must all think differently about challenges and resources. This presentation explores the need and the opportunities - for psychiatrists as well as other mental health professionals - to serve as leaders as we move beyond traditional ways of approaching treatment and care for those in need.

LGBT Mental Health: Health Care, Innovation, and Advocacy

Chair: Hossam M. Mahmoud, M.D., M.P.H.

Presenters: Michael S. Ziffra, M.D., Ariel Shidlo, Jill Rodgers-Quaye

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Realize the mental healthcare gap facing LGBT individuals and discuss barriers to care; 2) Explore the role of telepsychiatry in enhancing access to LGBT-affirming mental health services; 3) Review diagnostic and treatment considerations for working with LGBT patients; 4) Appreciate the impact that mental health providers create through healthcare provision and advocacy for LGBT asylum seekers; and 5) Discuss the intersection of LGBT mental health, healthcare innovation, and human rights advocacy

SUMMARY:

Lesbian gay bisexual and transgender (LGBT) individuals in the United States and many countries around the world continue to face major social, legal and health-related challenges. LGBT individuals continue to encounter violence, discrimination, societal stigma and denial of civil rights. In addition, armed conflicts,, human rights violations, and other forms of violence based on sexual orientation and gender identity are forcing LGBT individuals to flee their homes and their countries seeking asylum and refuge in “safer” countries. The above factors lead to higher rates of mental health conditions among members of the LGBT communities, particularly among LGBT refugees and asylum seekers. Concomitantly, LGBT individuals face numerous barriers to accessing mental health care. This session discusses the different roles that mental health professionals play, as clinicians, healthcare innovators, and human rights advocates in advancing LGBT mental health. From a clinical perspective, the session highlights different considerations when providing LGBT-affirming mental health care, including the role of factors such as discrimination, internalized stigma, intimate relationships, and body-image issues in shaping mental health presentations. The session also reviews psychosocial interventions of particular relevance to LGBT patients. From a healthcare innovation perspective, the session discusses the role of telepsychiatry as an approach to overcome barriers that LGBT individuals face in accessing mental health services and the potential of videoconferencing to enhance access to LGBT-affirming mental health care. From a human rights perspective, the session explores the role that mental health professionals can play in the application for asylum in the United States of LGBT refugees who flee persecution. The session specifically covers the role of mental health professionals in documenting the psychological sequela of anti-LGBT persecution and its impact on asylum seekers. Finally, the session closes with a panel discussion to explore the roles of mental health professionals in advancing LGBT mental health and highlights the intersection of LGBT-affirming clinical care, healthcare innovation, healthcare advocacy and human rights work in this field.

Management of Psychiatric Illness During Pregnancy and Postpartum: What Every Psychiatrist Needs to Know

Chair: Veerle Bergink

Presenters: Jennifer L. Payne, M.D., Samantha E. Meltzer-Brody, M.D., M.P.H., Lauren M. Osborne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) - The participant will be able to make a personalized treatment plan for pregnant and postpartum women using evidence based guidelines and the latest research findings; 2) - The participant will be able to understand the risks of most frequently used psychotropic medication as well as the risks of untreated illness to both the mother and her; and 3) - The participant will be able to identify which women are at highest risk during pregnancy and postpartum and how to prevent and treat episodes

SUMMARY:

Pregnancy and childbirth are profound life events, and this period can be particularly challenging for women with mental illness. Clinicians might find this period difficult because treatment approaches may need to be adjusted during the perinatal period, and general psychiatrists receive little training about pregnancy-specific treatment considerations. Moreover, decisions about psychotropic medication during pregnancy and lactation require thoughtful discussion between physician and patient to determine the best course of treatment that will ensure good outcomes for both mother and infant. Patients want to know what they can do to optimize their mental health stability and the health of their baby. This session will address these challenges and provide guidance on how to treat during pregnancy and the postpartum period. After an overview of the guidelines and recent updates in the perinatal psychiatric literature, the presenters will engage the audience in both small-group and large-group discussions about real-life cases. Cases will include a broad range of diagnoses in the perinatal period (including perinatal unipolar and bipolar depression, perinatal obsessive-compulsive disorder, perinatal primary psychotic disorders, and postpartum psychosis). We will provide an example of a

standardized format (one page) perinatal treatment plan and demonstrate how to work cooperatively with the patient to fill in this treatment plan. The plan will include information about medication during pregnancy and postpartum (including antidepressants, mood stabilizers, and first and second-generation antipsychotics), use of other treatments during pregnancy, mode of delivery/special care during delivery/indication for C-section, plans with regards to breastfeeding, the role of the partner/family, and special circumstances (premature babies, pregnancy complications, or labor and delivery complications). A key aspect of each group discussion will be education about treatment options, acknowledging that there is not always an obvious 'single best treatment option'. The speakers in this session are experts in perinatal psychiatry with both clinical and clinical research experience. Dr. Veerle Bergink is the Director of the Perinatal Psychiatry Program at the Icahn School of Medicine at Mount Sinai, Dr. Samantha Meltzer-Brody is the Director of the Perinatal Psychiatry Program at the University of North Carolina at Chapel Hill, Dr. Jennifer L. Payne is the founder and Director of the Johns Hopkins Women's Mood Disorders Center, Dr. Lauren M. Osborne is Assistant Director of the Women's Mood Disorders Center at Johns Hopkins University School of Medicine, as well as Chair of the National Task Force for Women's Reproductive Mental Health (a group that is developing evidence-based guidelines and creating a national, standardized curriculum in reproductive psychiatry for residents).

Managing Transgender Patients With Co-Occurring Psychiatric Illness Through the Surgical Process: A Discussion With Surgeons on Multidisciplinary Care

Chair: Dan H. Karasic, M.D.

Presenters: Lin Fraser, Ed.D., Scott Mosser, M.D., Jordan Deschamps-Braly, M.D., Andrew Watt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To be able to list potential impacts of psychiatric illness in transgender patients on surgical outcomes; 2) To be able to list principles guiding mental health evaluations for surgery in patients with co-occurring psychiatric illness, including substance use disorders; 3) To be able to

list particular areas of concern for patients with co-occurring psychiatric illness seeking genital surgery, facial feminization surgery, and breast/chest surgery; and 4) To be able to describe principles of multidisciplinary care of transgender patients

SUMMARY:

The care of transgender patients while transitioning can involve many disciplines, including psychiatrists and other mental health practitioners, primary care providers, and surgeons. The patient might present to the mental health practitioner with gender dysphoria or to explore issues of gender identity. Others may be referred by their primary care practitioner for a co-occurring psychiatric disorder. Referrals for surgery are guided by the Standards of Care of the World Professional Association for Transgender Health, which require mental health evaluations before some surgeries, and that co-occurring mental illness be addressed. Communication is formalized in the mental health consultation letters, but ideally involve ongoing communication between providers. Co-occurring psychiatric illness, including substance use disorders, can negatively affect outcomes in patients referred for surgery. Psychiatric illness can affect ability to give informed consent, ability to keep appointments and adequately prepare for surgery, and affect adherence to aftercare plans, e.g., dilation after vaginoplasty. Substance use can impair healing. Additionally, surgery-related stressors can be challenging to some with co-occurring psychiatric illness. In this session, mental health experts and surgeons discuss principles of multidisciplinary care and strategies for supporting transgender patients, particularly with co-occurring psychiatric illness, through the surgical process. The panelists include a surgeon primarily doing genital surgeries, a surgeon specializing in facial feminization surgery, and a surgeon whose focus is chest and breast surgeries. Through discussion with case vignettes, the particular challenges the perioperative period presents for patients with co-occurring psychiatric illness, and how these challenges are managed, will be demonstrated.

Mass Shootings and the Burden on Psychiatry

Chair: Ahmar Mannan Butt, M.D.

Presenters: Muhammad Hassan Majeed, M.D., Kyle LeMasters, D.O., Christopher Stefan, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the factors leading to increased number of mass shootings over the past decade;; 2) Identify prevalent misconceptions between gun violence and mental illness;; 3) Discuss and explore proposed interventions to avert such incidents; and; and 4) Understand the burden of these tragedies on psychiatry as a profession and on our patients.

SUMMARY:

The United States has the highest rate of deaths from firearms of any country in the world (1). A staggering number (60.7%) of these deaths were suicides. While the mass shootings often get the media attention, suicide, the most common cause of gun death, is often ignored. The CDC defines a “mass shooting” when three or more shooting victims (not necessarily fatalities), not including the shooter, are involved. The shooting must not be identifiably gang, drug, or organized crime-related (3). These tragedies result in a national flux of emotions, debate, and resolutions. However, over the past decade, the incidence of mass shootings has only increased. Mental health is often portrayed as a “critical ingredient” in these tragedies—from the media to the politicians (4). A closer inspection of the data has revealed that mass shootings by those who are mentally ill amounts to less than 1% of all gun-related homicides. Moreover, of all violent crime, only 3% involve those who are affected by mental illness (5). In the U.S. it is estimated, a person is fifteen times more likely to be struck by lightning than to be killed by someone with a chronic mental illness (6). Other sociocultural factors that have been implicated include a general pathological sense of self (narcissism), revenge fantasies, and glamorization of mass killing by the press. Mental illness continues to be used as a scapegoat for increased gun violence. This not only detracts from policymakers ability to address the exact causes of mass shootings but also adds to the cumbersome stigma regarding mental illness. The role of clinicians in asking, counseling and documenting possession or access to a firearm varies from state to state. The

U.S. Court of Appeals for the 11th Circuit has altogether barred physicians from asking any questions about gun possession while mandatory reporting is a requirement of the New York State Safe Act. At the federal level, the Gun Control Act of 1968 prohibits gun ownership of any person who has been “adjudicated as a mental defective” or “committed to any mental institution.” Our session will introduce participants to the history of mass shootings and its association with mental illness by reviewing landmark incidents in the United States. From real examples, we will discuss explanations other than mental illness behind such assaults. During our session, we will examine the steps to take if a provider suspects their patient is in possession of firearms, while minimally disrupting their therapeutic relationship. We will also review the cases in which patients have made threats to commit mass shootings or hoaxes spread by adolescent teens in school. Through group discussion, our audience will be encouraged to share and discuss instances where the current debate on mental illness and mass shootings has added to the ever-growing stigma of mental illness.

Mental Health Consequences of Separation for Immigrant Families

Chair: Alicia Lieberman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will learn the mental health manifestations of young children’s experience of separation from their parents; 2) Participants will gain knowledge of the challenges facing service providers working with immigrant children separated from their families during the separation and after reunification.; and 3) Participants will frame their knowledge of the impact of child separation in the context of the stresses of immigration and the traumatic stress inflicted by immigration enforcement policies

SUMMARY:

Separating children from their parents can have both immediate and long-term deleterious effects on the child’s mental health, setting off a cascade of stress reactions that may shape the child’s biology, brain structure, and emotional, cognitive, and behavioral

functioning for years to come. Early studies of child separation revolutionized our understanding of young children’s experience and became the foundation of the field of early childhood mental health, but this knowledge has not been systematically incorporated as an integral component of clinical practice and public policy. This presentation will describe the scientific and clinical knowledge about the mental health consequences of separating children from their families, framing this discussion in the context of immigration enforcement practices that systematically harm children and families and threaten the fabric of our social institutions and public trust in the social contract of protecting children from harm

Mental Health in Latin America: Commitment and Collaboration in the Road of Transformation

Chairs: Renato D. Alarcon, M.D., Ruby C. Castilla Puentes, M.D.

Presenters: Victoria Valdez, M.D., Ricardo Secin, Arturo Grau

Discussant: Sebastian Cisneros, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Examine the complexities and intersections of multiple factors e.g., socioeconomic status, and cultural background, and their impact on mental health in Latin American countries.; 2) Evaluate the impact of innovative research programs addressing mental health disabilities in Latin American populations.; 3) Recognize the importance of sociocultural context and variables in the psychiatric diagnostic approach aimed at improved outcomes in mental health care of Latin American populations.; and 4) Understand how educational programs can mediate the relationships between mental illness, disability and stigma.

SUMMARY:

Mental health programs throughout the last five decades have led to relevant improvements of mental health services in several Latin American countries. They have also contributed to the development of new evidence that may help in the implementation of local policies. This Symposium will describe significant initiatives in the field and will document a variety of facilitating factors in their

processing. A unique Consultation Liaison program developed in Mexico, is presented, emphasizing a positive sharing of defining basic knowledge and clinical skills by experts, academicians and trainees. A study in Ecuador investigating post-traumatic stress disorder among adults survivors of the 7.8 magnitude earthquake. It is followed by a review of an academic program Psychiatry and Psychology of Childhood in Chile. At the end, the discussant will summarize the main topics and the panel will be open for questions, answers and comments from attendees regarding the material presented.

Mental Health Reform

Chair: Richard Frank, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) TBA; 2) TBA; and 3) TBA

SUMMARY:

Major advances in mental health policy have been made over the last decade. Moreover, tests of early intervention programs have infused new optimism in the ability to attenuate the disabling effects of severe mental disorders. Yet the challenges of accessing quality mental health care, criminalization of mental illnesses and attending to the disabling effects of these illnesses persist. In this lecture I will review the recent progress in public policy towards mental illnesses, examine the policy efforts that can address some of the remaining challenges and touch on the challenges that the evolving economy will pose to the mental health community.

Moral Injury, Suicide Risk, and the Role of Religion/Spirituality in Recovery

Chair: Donna Ames

Presenters: Marek S. Kopacz, M.D., Ph.D., James T. Luoma

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define moral injury and at least three components of this syndrome.; 2) Understand how each of 5 major religions approaches moral injury.; 3) Demonstrate ways to measure moral injury symptoms.; 4) Describe how chaplains or faith-based partners in the community can

collaborate on the treatment of moral injury.; and 5) Recognize the association of moral injury, suicide and spiritual struggles.

SUMMARY:

Morally injurious events can occur in the setting of war. The consequences of these events can be spiritual or religious struggles as one grapples with having done something or witnessed something that goes against one's moral beliefs. Veterans with religious backgrounds, in particular, may be even more vulnerable to this type of injury. Dr. Ames will provide a summary of her work with Dr. Koenig in developing a scale that can help clinicians detect moral injury in Veterans. She will then review development of two novel spiritually-integrated clinical interventions that are being tested for the treatment of moral injury. She will also discuss her recovery-oriented, holistic, bio-psycho-social-spiritual approach to the Veterans she works with in mental health rehabilitation clinical settings, whom suffer from moral injury. Dr. Kopacz will review the data on suicide risk amongst persons with PTSD and moral injury. He will also review a novel chaplain intervention being tested at his facility as well as data on the role chaplains play in the VA Healthcare System. Dr. Kopacz and Dr. Ames will discuss with the audience the benefits of collaboration with chaplains and community religious partners in grappling with moral injury. Chaplain Luoma will discuss his work with Veterans with moral injury as well as his personal experiences with overcoming PTSD and moral injury. Attendees will learn about the clinical significance of moral injury, how to evaluate it and options for treatment through collaboration with chaplains. The ultimate goal is to help clinicians weave a bio-psycho-social-spiritual approach into their recovery plans for Veterans.

My Personal and Professional Journey Through Autism: Update on Autism Treatment Through the Lifespan

Chair: Ilana M. Slaff, M.D.

Presenter: Julie Russell, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the antecedents, behaviors and consequences of problem behaviors,

list the four functions of a behavior (tangible, attention, escape/avoid, sensory) to analyze data for a behavior plan; 2) Learn how to use visual supports to improve problem behavior, such as visual timers, picture communication, and augmentative communication devices; 3) Describe how exercise and diet can influence behaviors and how applied behavior analysis can improve diet, exercise and sleep; 4) Understand basic education law to advocate for placements which provide effective interventions; and 5) Learn behavioral interventions such as differential reinforcement of other behaviors and how to use them to improve adherence with medical procedures

SUMMARY:

Although individuals with autism can have comorbid conditions requiring medication management, polypharmacy is often used to treat autism spectrum disorders although lacking in evidence and educational approaches are underutilized. The evidence and side effects of medications more likely in individuals with autism will be discussed. Methodologies to treat problem behavior including evidence of behavioral educational treatments such as applied behavior analysis will be described. Many psychiatrists are unaware of how collaborating with a board certified behavior analyst can improve treatment outcomes. Different types of functional behavior assessments including rating scales and direct observations for problem behaviors and analyzing data will be discussed. Behavior intervention plans such as differential reinforcement of other behavior (DRO) and functional communication training (FCT) to reduce problem behaviors will be discussed. Fixed versus variable reinforcement will be presented. Evidence on effectiveness of parent training to reduce medication management will be presented as well as using goal specific statements to improve behaviors. Evidence will also be presented on how using mindfulness can improve parent training. Utilizing applied behavior analysis approaches to reduce psychiatric hospitalization and abuse will be discussed. A brief introduction to education law and advocating for funding for applied behavior analysis programs for individuals with problem behaviors will be presented. Applied behavior analysis studies to improve sleep and feeding issues and adhere to

medical procedures will be discussed. Research will be presented to show that applied behavior analysis procedures can also be effective for individuals who do not have autism. The use of visual supports to reduce anxiety and agitation will be presented. Simple dietary interventions and benefits of exercise on problem behaviors will be discussed as well as how to use applied behavior analysis approaches to adhere to them. Personal case examples with videos will be shown.

Narcissism, Power and Empathy in the American Psyche: Historical and Clinical Perspectives

Chair: Ravi Chandra, M.D.

Presenters: Glen Owens Gabbard, M.D., Dacher Keltner, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand and describe historical, social and cultural components of narcissism in America.; 2) Understand social media's positive and negative influences on personality.; 3) Understand the effects of power on empathy.; 4) Understand how emotions influence judgments of causality, fairness, and risk.; and 5) Describe clinical and cultural implications of narcissism, power and empathy.

SUMMARY:

Personality is influenced by social and cultural factors. From the founding of the country, the United States has emphasized individualism at best, self-centeredness and devaluation of those deemed "others" at worst. The cultural sirens, from the pursuit of happiness, manifest destiny, and materialism have emphasized individual attainment, ambition, self-expression and creativity, often at the expense of the general welfare, particularly the commonweal of vulnerable groups. Research has suggested there's been a cultural shift towards individualism over the last 50 years, a system that places more emphasis on the self and less on others. Individualism as an archetype of the American psyche throughout history, and self-centered individual and tribal group identity have become significant social issues. Studies find that Americans are now more extraverted, narcissistic, and confident and less connected to others through both

personal contact and civic engagement. With its emphasis on attention-seeking and electronic communication, social media may have hastened these trends in recent years. The perceived strengths of individualism, in attaining and asserting power, have effects on empathy. The emotions of an individual under threat (anger, sadness and fear, for example) can influence judgments of causality, fairness, and risk. The implications for society and individual mental health of an increase in narcissistic traits and change in quality of relationships are profound and far-reaching. Understanding this research and the historical and social context of narcissism can help clinicians understand the challenges their patients face, and guide them towards appropriate remedies. Alternatives to narcissism and self-centeredness are important for both individual and communal mental health. Glen Gabbard provides historical and clinical expertise on narcissism. Ravi Chandra provides historical context and insight into American culture and social media. UC Berkeley social psychologist and director of the Greater Good Science Center Dacher Keltner provides research expertise on power, empathy, emotions and moral reasoning.

Neuropsychiatry of Traumatic Brain Injury

Chair: Jonathan M. Silver, M.D.

Presenters: David B. Arciniegas, M.D., Thomas Walker Mc Allister, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the complex neuropsychiatric outcomes from TBI, including psychiatric and somatic disorders.; 2) Develop the expertise to diagnose neurocognitive, mood, and anxiety disorders as well as emotional and behavioral dyscontrol after TBI.; 3) Understand the expected symptoms and trajectory of recovery after concussion.; 4) Recognize risk factors for the development of persistent symptoms after concussion.; and 5) Understand the definitions and controversies of chronic traumatic encephalopathy.

SUMMARY:

Despite the increased public awareness of traumatic brain injury (TBI), the complexities of the neuropsychiatric, neuropsychological, neurological

and other physical consequences of TBI of all severities across the lifespan remain incompletely understood by patients, their families, healthcare providers, and the media. This symposium will provide an update on the neuropsychiatric perspective on TBI. Diagnosis and the key elements of assessment, including common physical conditions will be reviewed. Psychiatric disorders after TBI, include neurocognitive, mood, anxiety disorders and emotional and behavioral dyscontrol. "Concussion" as a specific type of mild TBI will be reviewed, including the natural history of recovery and atypical outcomes, highlighting recent findings from the Department of Defense/NCAA studies. Controversies and clarification about chronic traumatic encephalopathy (CTE) will be discussed.

New Directions in HIV Psychiatry: Prevention and Wellness in the Fourth Decade

Chair: Mark V. Bradley, M.D.

Presenters: Mary Ann Adler Cohen, M.D., Kelly Lynn Cozza, M.D., John A. R. Grimaldi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the evolving role of psychiatrists in HIV testing and early intervention for both treatment; 2) Evaluate the essentials of pre-exposure prophylaxis (PrEP) for individuals at risk for HIV and the relevance of PrEP to psychiatric practice; 3) Review the latest available antiretroviral medications and identify psychiatric barriers to effective antiretroviral adherence; and 4) Describe how to prevent HIV infection with post-exposure prophylaxis (PEP) in HIV negative persons even after accidental exposure to HIV during sex or injection drug use

SUMMARY:

The evolution of the HIV epidemic, including advances in the treatment of HIV and AIDS, has substantially altered the role of psychiatrists in the care of people living with HIV. In contrast to the first decades of the epidemic -- when HIV psychiatrists frequently encountered a rapidly fatal illness with severe CNS consequences -- current priorities include applying psychiatric principles in order to optimize illness management and prevent viral transmission. It is essential that psychiatrists working

with persons with HIV understand the most current evidence supporting the role of psychiatry in maintaining optimal medical and public health outcomes in HIV disease. This symposium, sponsored by the APA Council on Consultation-Liaison Psychiatry, will explore current theory and research underpinning novel roles for psychiatrists in the prevention and treatment of HIV/AIDS. Dr. Mary Ann Cohen will provide an overview of the integration of medical and psychiatric care in a way that supports HIV testing, early intervention, "treatment as prevention" (TasP, the use of antiretroviral treatment as a strategy to reduce HIV transmission by suppression of viral load) and post-exposure prophylaxis (PEP). Dr. Mark Bradley will review theoretical models supporting behavior change with respect to HIV prevention and antiretroviral adherence, as well the evolution of these models in the face of new biomedical prevention approaches. Dr. Bradley will then discuss the relevance and applications of new prevention approaches for psychiatrists working with HIV-infected and at-risk patients. Dr. John Grimaldi will focus on evidence supporting the use of pre-exposure prophylaxis (or PrEP, the use of antiretrovirals in HIV-negative individuals) to reduce HIV infection risk in patients with psychiatric illness, focusing on concerns often faced by clinicians considering using this preventative intervention. In addition, Drs. Grimaldi and Bradley will discuss an ongoing study examining the potential role of psychiatrists in biomedical HIV prevention. Finally, Dr. Kelly Cozza will review recently introduced antiretroviral medications, emphasizing the newest solo and combination regimens, as well as their relevant metabolic properties, side effects, toxicities, interactions with psychotropics, and the impact of these regimens on antiretroviral adherence. The session will conclude with audience question-and-answer and panel discussion.

Novel Approaches to Understanding, Identifying, and Treating Suicidal Impulsivity

Chair: David V. Sheehan, M.D., M.B.A.

Presenters: Jennifer M. Giddens, Danilo W. Quiroz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand general trait impulsivity and specific suicidal state impulsivity; 2) Understand the phenomena and functional impairment associated with suicidal impulsivity; 3) Understand how to question patients about suicidal impulsivity and monitor this over time; 4) Understand how to identify impulsive suicidality; and 5) Understand the importance of identifying patients with impulsive suicidality prior to prescribing pharmacological treatments for suicidality

SUMMARY:

62% of suicide attempts are impulsive rather than planned. Yet there has been more focus on assessing future suicide plans and intent while giving less attention to understanding the nature of impulsive suicidality. 1. Impulsive Suicidality: A Brief Review of Literature Dr. David V. Sheehan, MD, MBA, DLFAPA, Distinguished University Health Professor Emeritus at the University of South Florida College of Medicine, Tampa, Florida, USA Dr. Sheehan will share a brief review of the literature on the relationship between impulsivity and suicidality. 2. Unexpected Suicidal Impulse Attacks and Impulse Attack Suicidality Disorder Jennifer M. Giddens, BA, University of Florida College of Public Health and Health Professions. Gainesville, Florida, USA. Jennifer Giddens will share a description of a unique phenotype of suicidality where patients experience an unexpected, unprovoked sudden urge to make a suicide attempt. This presentation will describe the phenomena associated with these Unexpected Suicidal Impulse Attacks and with Impulse Attack Suicidality Disorder including associated functional impairment and specific questions which can be used to assess this unique suicidal phenomenon. 3. Case Studies of Magnesium in the Treatment of Impulse Attack Suicidality Disorder Dr. Danilo Quiroz, Director Académico Fundación Neuropsiquiátrica de Santiago – NEPSIS & Profesor Adjunto Universidad Diego Portales, Santiago, Chile and Dr. David V. Sheehan, MD, MBA, DLFAPA, Distinguished University Health Professor Emeritus at University of South Florida College of Medicine Dr. Quiroz and Dr. Sheehan will present studies on the use of magnesium oxide in the treatment of Impulse Attack

Suicidality Disorder, including patient videos. 4.
Panel Discussion: Questions and Answers

On the Future of Psychotherapy Research

Chair: Mardi J. Horowitz, M.D.

Presenters: Mardi J. Horowitz, M.D., Barbara Milrod, M.D., Daniel Le Grange

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand progress achieved through randomized clinical trials of psychotherapy; 2) Learn new methods for psychotherapy planning; and 3) Be able to use steps of configurational analysis for process research

SUMMARY:

The three presentations by experienced psychotherapy researchers will cover research designs such as randomized clinical trials, intensive case analyses and process research. Presenters will interact with each other and with members of the audience to consider future designs for research on psychotherapy. The goal is to elucidate the types of research that demonstrate and advance the efficacy of psychotherapy.

Personality Disorder Patients Overwhelm Me! Using Transference-Focused Psychotherapy (TFP) Principles as a Practical Risk Management Strategy

Chairs: Richard G. Hersh, M.D., Lois W. Choi-Kain, M.D.

Presenter: Benjamin H. McCommon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn the essential elements of TFP that can be used by the general psychiatrist in a variety of clinical settings; 2) Introduce the structural interview and its value in the assessment process; 3) Actively engage partners and families of patients with personality disorder pathology in a way that benefits the patient and serves as a useful risk management tool; 4) Develop a treatment frame using contracting that allows for the safe and effective management of patients with significant personality disorder pathology in multiple settings; and 5) Use TFP principles in pharmacologic management

SUMMARY:

Transference-Focused Psychotherapy (TFP) is an evidence-based treatment for patient with borderline personality disorder (BPD). TFP as an individual psychotherapy unfolds in a specific and deliberate manner that includes: 1) a comprehensive evaluation process that aims to capture both personality disorder category as well as severity of illness, 2) open discussion with patients and family about personality disorder diagnoses, 3) clarification of the patient's personal goals and treatment goals, and 4) an extended process of treatment contracting that aims to create a safe environment for both patient and clinician. More recently TFP's use has been extended to patients with other moderate to severe personality disorder presentations. TFP principles can be used by clinicians in a variety of clinical settings outside of the traditional extended individual psychotherapy modality. We will introduce participants to the essential elements of TFP and describe the ways the general psychiatrist can use TFP principles in practice to manage risk in the treatment of patients with primary or co-occurring personality disorder pathology. Clinicians are understandably concerned about risk when encountering patients with personality disorder pathology; this has led to considerable stigma in the field and many clinicians' attempts to avoid treatment of this population. Nevertheless, clinicians will encounter patients with personality disorder pathology in almost every clinical setting. We will engage participants in this session about their experiences working with patients with borderline and other personality disorders and the pitfalls they have encountered in such situations. We will offer the TFP approach as one way to address frequently observed challenges including: 1) risks of unnecessary hospitalizations, 2) counterproductive polypharmacy, 3) boundary violations, and 4) risks of patient abandonment

Physician Health Programs (PHPs): Battling Burnout, Combating Stigma, and Empowering Physicians to Be Great Again

Chair: Lama Bazzi, M.D.

Discussants: Christopher Paul Marett, M.D., M.P.H., Elie Aoun, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the role PHPs play in the treatment of physicians with addictions; 2) Appreciate the ways in which PHPs differ among states and the impact this has on their effectiveness; 3) Understand the relationship between PHPs and physician licensing boards and the challenges faced by physicians faced with navigating both systems; and 4) Appreciate different solutions for the obstacles facing physicians with addictions seeking treatment, overcoming their impairment, and retaining their ability to practice medicine

SUMMARY:

Several recent studies suggest that over 35% of practicing physicians meet criteria for burnout, and with burnout comes increased vulnerability to substance use disorders, mental, and physical illnesses. These conditions can impair their ability to practice medicine and potentially affect patient care. PHPs are meant to be a confidential resource that physicians with substance use disorders, medical and psychiatric illnesses can use to seek treatment. PHPs aim to effectively detect, evaluate, treat, and monitor impaired physicians. They can then provide medical licensing or other regulatory boards with documentation evidencing compliance to treatment and ongoing recommendations. The goal is to ensure physicians in treatment and recovery can continue to practice medicine and provide care to patients without compromising public safety in any way. Despite all PHPs having the same mission, they vary greatly between states. Their role, effectiveness, and communication with licensing boards vary greatly depending on their funding, their structure, and levels of staffing. Although differences allowed these programs to interface between licensing boards and impaired physicians, the variations are now prohibiting further growth. Through practical examples, the session will identify the challenges that these programs have faced. Through charts and other visual representations, the panel will explain the interstate differences in funding, resource, structure and oversight between PHPs. Case studies will highlight the struggles that physicians have faced while obtaining treatment at PHPs. Audience polling will be used to further advance the panel's discussion of root causes behind causes of psychiatrist burnout in particular and the potential

reluctance of physicians have to seeking resources and treatment through PHPs. Lastly, an interactive discussion will engage the audience in brainstorming realistic solutions that allow PHPs to abide by state specific policies while streamlining areas where variation between states is unnecessary and disadvantageous. The panelists have a common interest in fields of forensics and addiction psychiatry and each play a role in promoting physician wellness.

Physician Impairment: Clinical and Legal Issues

Chair: John S. McIntyre, M.D.

Presenters: John S. McIntyre, M.D., Jeffrey Alan Selzer, M.D., Michael H. Gendel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the definition of physician impairment.; 2) Participants will recognize the common signs of physician impairment; 3) Participants will understand why physician impairment is under-reported; 4) Participants will understand the workings of Physician Health programs; and 5) Participants will be able to identify the steps in making a referral to Physician Health programs.

SUMMARY:

Physician Impairment is a very significant Public Health issue and a major challenge for the medical profession. Various definitions of impairment will be discussed including the American Medical Association's description of impairment in its Ethical Opinions. The imperatives associated with being a "profession" will also be reviewed with respect to impairment. Issues concerning impairment in other positions of authority such as the Presidency of the U.S. will also be identified. A central theme of this Forum will be that the diagnosis of "illness" does not equate with "impairment". Issues of stigma, both with physicians and others have a major impact on how these matters are dealt with and will be considered. The role of State Licensing Boards/ Boards of Medicine in "protecting the public" will be described. The composition of the Boards and their patterns of functioning will be explored including their variability across States. Policies of the Federation of State Medical Boards (FSMB) with

respect to impairment will be described. Identification of physician impairment will be another major foci of this Forum. In the large majority of cases, self-identification does not occur largely due to denial, fear of consequences and lack of feedback from family and colleagues. The reasons for this relative silence from family and colleagues will be explored. In the past decade there has been some improvement in the involvement of colleagues but it is still far from optimal. Recent studies have also identified the potential role of patients in identifying physician impairment. The issue of age has been an important and challenging matter. Mandatory retirement age policies are being replaced by functional assessments in a number of settings. In the late 1960's some States passed "sick doctors" statutes. These legislative initiatives supported the referral for help for "distressed, ill or addicted physicians." This has contributed to the development of Physician Health programs. State laws that protected the confidential work of these programs led to their growth as well as their effectiveness. This forum will consider in detail two Physician Health Programs – New York and Colorado. The history of these programs and their development will be described and key policies will be identified. Statistics will be shared about number of physicians in these programs and their outcomes. Case vignettes will be included to increase the understanding of identification of impairment, techniques to increase the participation of impaired physicians in these programs and some outcome data including the percentage of physicians who remain in/return to active practice. A significant amount of time will be left to engage the audience in discussion and questions.

Physician Leadership for IMGs: An Affair of the Mind and Heart!

Presenters: Britta Ostermeyer, M.D., Swapna Deshpande, M.D., Vijayabharathi Ekambaram, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participants will be able to appreciate physician leadership opportunities to improve provider health care practice settings and patient health care delivery.; 2) 2. At the conclusion of this

session, the participants will be able to understand core leadership facts they should master for successful physician leadership careers.; and 3) 3.

At the conclusion of this session, the participants will be able to name interventions to improve their leadership skills.

SUMMARY:

The Institute of Medicine (IOM) estimated that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of preventable medical errors. Both IOM and the Joint Commission have cited poor leadership and poor communication as major causes for these sentinel patient care events. Additionally, ineffective and destructive leadership styles lead to poor performance, psychological and/or physical damage, frequent employee job turnover, and painful administrative or legal disputes in the workplace setting. It is important to help physicians, including International Medical Graduates (IMGs), recognize that leadership and communication skills are critical tools, which can dramatically improve patient care outcomes as well as open the door to tremendous career opportunities. While business and accounting/finance skills are good administrative tools, research has yielded other facts and findings that also facilitate excellent leadership performance. By using A) a combination of illustrative role-play vignettes under the direction of Dr. Swapna Deshpande and acted out by faculty and trainees from the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma, Oklahoma City, and B) presentation slides, this session will discuss important leadership truths based on work by internationally renowned leadership experts, Kouzes and Posner. The session will discuss the important leadership attributes pertaining to belief in oneself, credibility, trust, values, vision, teamwork, challenges, learning and growth of leaders, and the nurturing and empowering of others. In particular, the important role of nurturing, appreciation, and love for one's profession, team members/employees, and missions will be highlighted. After all, successful and prosperous leadership is also an affair of the heart. Finally, this presentation will identify and discuss interventions and opportunities to improve physician leadership skills, such as business and communication

leadership training opportunities and executive leadership coaching sessions.

Physician Suicide: Preventive Strategies for the Practicing Clinician

Chair: Michael F. Myers, M.D.

Presenter: Peter M. Yellowlees, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand novel and creative ideas about what leads to suicidal thinking and planning in today's physicians; 2) Identify helpful strategies in the initial and ongoing treatment of suicidal physicians; 3) Delineate preventive educational and cultural change strategies designed to reduce the incidence of physician suicide; 4) Learn how to work in a less stressful hybrid manner, online and in-person, using multiple digital technologies to communicate with patients; and 5) Interact with each other and acquire professional confidence when treating psychiatrically ill medical colleagues

SUMMARY:

In June of 2018, the Centers for Disease Control and Prevention (CDC) issued an alarming report: suicide rates have increased by more than 30 percent in half of the states since 1999. This could mean that the oft-reported statement of the American Foundation for Suicide Prevention that 3-400 physicians die by suicide each year might warrant revision upward. New and creative approaches to understanding the drivers of physician suicide and implementing life-saving interventions are essential. This workshop is an amalgam of the combined perspectives and experiences of two senior psychiatrists who have been treating physicians throughout their decades-long careers. Both have recently published books on physician suicide. Over 20 minutes, Dr Myers, concentrating on his qualitative research on families of physicians who have taken their lives, will discuss: the ways in which these individuals hold valuable and potentially lifesaving observations and suggestions; the finding that 10-15 percent of physicians who die by suicide receive no treatment; the ubiquity and magnitude of stigma in today's physicians, stigma that is paralyzing and pernicious; the feelings of exclusion these individuals have felt by their loved one's caregivers; their plea for more

basic education about common psychiatric illnesses in doctors; their belief that both their loved one and caregiver avoided exploration of suicidality; and their urgent wish to become involved in saving the lives of other physicians. Over 20 minutes, Dr Yellowlees will outline his interests in preventing illness and suicide in physicians by educating the physician workforce about psychiatric disorders that may affect them, as well as how to recognize these in themselves and colleagues and in parallel how to improve their own resilience. He will also discuss the need to change the culture of medicine and reduce the stigma of psychiatric disorders as well as the need for physicians to learn to work differently, and in a less stressful and hybrid manner, online and in-person, using a variety of digital video and mobile technologies to communicate with patients. Attendees are encouraged to bring questions and disguised case examples from their practices for the 50 minute discussion period.

Pit Appointments: Collaborative Psychiatric Assessments With a Psychiatrist, Family Physician, and Patient Inspired by Atul Gawande

Chair: Marilyn Thorpe

Presenter: Helen Monkman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what a pit appointment is; 2) Identify the essential criteria of a pit appointment; 3) Describe the process of a pit appointment; and 4) Appreciate when a pit appointment can be used as an alternative to a full psychiatric consultation

SUMMARY:

It is well documented that family physicians see many patients with mental illness. Wait lists for psychiatric consultation are long. At University of Victoria, University Health Services, wait times for psychiatric consultation averaged 43 days (up to 217 days) from 2013-2014. In an effort to reduce wait times, we piloted "pit appointments" which were inspired by Atul Gawande's 2012 TED talk (How do we heal medicine?) where he proposed that medical staff function like a pit crew in a car race, arriving with a well-defined role and working quickly and collaboratively. Over 2 years, we did collaborative 30

minute appointments attended by a family doctor, psychiatrist, and patient addressing particular questions of the family doctor and patient. Wait times for a pit appointment were 10 days and, because less full psychiatric consultations were needed, those wait times decreased to 15 days. Feedback from family physicians, psychiatrists and patients is positive. We worked to refine and curate our approach. We understand which patient problems are best suited to a pit appointment. We can now define the process which starts with a referral form completed by the family doctor, often with the help of the patient. A patient information sheet is available. A 30 minute pit appointment begins with 5 minutes where the family doctor briefs the psychiatrist on the case and reviews the goals of the family doctor and patient. For the next 20 minutes, the patient joins and the psychiatrist delves into the issue and concludes with recommendations in layman's terms. The final 5 minutes are spent with the psychiatrist documenting the session in the clinic's electronic medical record and the family doctor writing prescriptions and arranging other treatments and follow up as necessary. Pit appointments capitalize on the relationship between family physicians and their patients utilizing what the family doctor already knows (often missing in the psychiatric emergency department) and using the secure relationship to allow the psychiatrist to delve deeply for answers and then leave the patient in the care of the family physician. This saves time needed to gain the patient's trust during a traditional psychiatric consultation. By implementing pit appointments as stepped care between a phone consultation and a full psychiatric consultation, advantages potentially include shorter wait times and faster recovery, less use of the emergency department, and significant family physician learning about diagnoses, treatments and understanding coping and personality patterns. We will discuss what is essential for a pit appointment, what makes a good appointment and what contributes to the failure of an appointment. A video illustrates a good pit appointment. The audience will role play a pit appointment. A manual providing the tool kit to implement the appointments including suggestions for evaluation measures (pdf) is available

Placing Justice and Health Equity at the Center of Residency Education: A Case Study of New Initiatives at UCLA

Chairs: Nichole I. Goodsmith, M.D., Ph.D., Sonya Shadravan, M.D.

Presenters: Enrico Guanzon Castillo, M.D., Nicolas E. Barcelo, M.D., Isabella Morton, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least 3 components of a comprehensive educational strategy to increase residents' knowledge, skills, and attitudes in health/healthcare disparities, health equity, and social justice; 2) Identify at least 2 didactic formats for the teaching of structural bias, critical race and gender theory, and identity politics; 3) Identify at least 2 actions psychiatry departments and training programs can take to promote a culture that promotes the recruitment and retention of underrepresented minority faculty and residents; 4) Describe at least 2 educational strategies to promote attitudes toward careers in public service, particularly in the fields of community psychiatry and global mental health; and 5) Describe at least 3 common facilitators and barriers in addressing and advancing social justice in residency education

SUMMARY:

Many academic psychiatry residency programs feature tailored research tracks serving as professional pathways for advancement as physician researchers. These tracks include recruitment processes, mentorship opportunities, protected time from clinical responsibilities, flexibility in scheduling, and clear expectations regarding academic productivity. Despite national attention dedicated to promoting health equity, there remains a paucity of similarly designed tracks aimed to support residents in preparing for careers working to promote systems-level changes and combat mental health disparities. In response to these needs, a coalition of residents and faculty at UCLA have taken a multi-pronged approach to cultivate a shift in departmental culture while simultaneously building resident opportunities. This approach incorporates: 1) the creation of scholarly tracks in both community psychiatry and global mental health; 2) programming including monthly social justice teach-ins,

networking activities, field visits, and careers seminars by local leaders in community psychiatry and global mental health; 3) resident recruitment strategies that promote “holistic review” and increased recruitment and retention of underrepresented minority applicants; and 4) interdepartmental efforts to promote a culture of solidarity and support for historically marginalized residents and faculty. This workshop will provide concrete examples of how resident-inspired ideas can be embraced by residency training directors and institutionalized by departmental leadership, leading to cultural shifts within an entire department. Speakers will address the pragmatic and philosophical elements guiding their work. They will provide examples of successes, challenges and shortcomings in their organizing efforts, and invite the audience to share their own efforts and brainstorm possibilities for change at their home institutions.

Planetary Health: Can We Heal and Sustain a Good Enough Mother Earth?

Chairs: David Alan Pollack, M.D., Janet Lisa Lewis, M.D.

Presenter: Jonathan Patz

Discussants: Robin Julia Cooper, M.D., Lise Conway Van Susteren, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain a clear understanding of imminent and critical risks to general, mental, public, and planetary health posed by climate change.; 2) Understand, endorse, and be motivated to participate in efforts to educate colleagues, trainees, and the general public regarding the health and mental health aspects of climate change; and 3) Recognize the validity of the ethical obligation to warn others of the relevant planetary and individual health risks/remedies associated with climate change.

SUMMARY:

Abundant evidence exists demonstrating that Climate Change (CC) is real, immediate, and catastrophically severe in its anticipated outcomes. More disturbing is the fact that sufficient information was known 40-50 years ago to spur

more progressive action that could have averted the disastrous state that the earth is now experiencing and expecting. Denial has dominated policy, political, and economic decisions and action at cultural and economic levels throughout the nations of the earth, but more currently and distressingly in the United States. Unless and until the world awakens to this reality and its implications for the health and mental health of individuals and communities throughout the earth, the worst can be expected. What we are facing is derived from the overall health of the earth being threatened by excessive carbon released into the atmosphere and derivative geophysical consequences. How can we heal the earth and, by so doing, maintain and improve the health of the population of this planet? What amount of harm can the earth sustain without having overwhelming and catastrophic impacts on its inhabitants, both flora and fauna? This case conference will be framed around understanding the current health status of Mother Earth, our patient. We will address the diagnostic, etiologic, treatment, outcome, prognosis, and prevention factors that relate to the planet’s current and future health status, with some emphasis on the mental health consequences.

Police Brutality and Black Americans: Evaluating the Problem, Understanding Its Impact on Mental Health, and Finding Solutions

Chairs: Christopher James Hoffman, M.D., Walter E. Wilson, M.D., M.H.A.

Presenters: Alexander Chung-Yu Tsai, M.D., Sarah Yvonne Vinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore the current problem of police brutality against black Americans; 2) Understand the population mental health impacts of race-related police brutality within the black community; and 3) Discuss specific solutions aimed to decrease the risk of police brutality against black Americans and how psychiatrists can promote the use of these interventions

SUMMARY:

Brutality of African-American males by law enforcement has spawned widespread national protests and generated justifiable national concern.

Repeated examples and depictions of police brutality and use of unwarranted deadly force against black males has a profound impact on the psychological well-being of African-American families and communities, creating a living environment of fear and uncertainty. Blacks are significantly more likely to experience police brutality than whites (Kahn, 2016). Additionally, young black men were 9 times more likely than other Americans to be killed by police officers as of data collected in 2015. Perceived racism and discrimination are also associated with depression, increased substance use, and feelings of hopelessness among African American youths (Gibbons, 2004; Nyborg, 2003), which in turn are associated with suicidal behaviors in adolescents (Goldston, 1999; Goldston et al. 2001). The effects of overt and covert racism, as well as explicit and implicit bias on mental health have been well documented. Racial profiling resulting in frequent police stops and searches has been associated with symptoms of anxiety and PTSD (APA, 2017; Aymer, 2016). There needs to be more exposure of the fact that there have been a number of very concerning cases of African-American females unjustly losing their lives at the hands of law enforcement. This phenomenon has been highlighted by the #SayHerName Campaign. Black females are disproportionately stopped and killed by police at higher rates compared to white women (Washingtonpost.com, 2018). There is also evidence that gender and sexuality policing disproportionately affects black transgender and gender non-conforming women. Profiling of black transgender women, along with black non-transgender women for prostitution related offenses is rampant, sometimes based on the mere presence or possession of a condom (Amnesty International, 2005). The overlap of sexism, racism, homophobia, and transphobia place black LGBTQ and gender-nonconforming people in a precarious position at the intersection of constructs around gender, race, and sexuality, fueling police violence against them (Mogul, Ritchie, & Whitlock, 2011). It is crucial that psychiatrists are knowledgeable on how social issues impact our patients. It is also important that psychiatrists develop the skill set to advance advocacy efforts that can lead to policy change. Presenters will discuss how police brutality is affecting our communities; engage the audience in

discussion of personal experiences and media depictions on the topic of police brutality; and discuss how psychiatrists can promote the use of interventions aimed at decreasing police brutality.

Proactive Versus Reactive Consultation-Liaison Services in Medicine and Pediatrics

Chair: John T. Walkup, M.D.

Presenters: Hochang Benjamin Lee, M.D., Alba Perjjika, M.D., Susan Friedland

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the end of the presentation the participant will be able to describe the differences between Proactive and Reactive CL; 2) At the end of the presentation the participant will be able to discuss the positive impact of Proactive CL on medical cost of hospital care and length of stay in general medical inpatient services; 3) At the end of the presentation the participant will be able to discuss the adaptation of the Proactive CL Program for Pediatric Inpatient Services; and 4) At the end of the presentation the participant will be able to discuss the application of the Proactive CL Model to Pediatric Primary Care

SUMMARY:

The traditional psychiatric consultation liaison (CL) model is reactive in approach. The consult request is usually initiated after the problem been identified and at a point more likely resistant to intervention. The Proactive CL model initiates intervention coincident with or in anticipation of admission to the hospital and is conceptualized as part of routine medical care offered on the inpatient unit. The need for a change in the traditional CL model in critical to health care as psychiatric and substance use comorbidity with physical illness in medically hospitalized adults and children is associated with higher cost, poorer outcomes and staff dissatisfaction. Higher cost is accrued as a result of greater lengths of hospital stay, greater cost per admission, and higher rate of readmission. Longer recovery time, increased complications, and greater mortality account for poorer outcomes. Staff dissatisfaction is high due to inefficient delivery and transfer processes, lack of staff training and expertise with mentally ill patients, and delayed

requests for assistance. The Proactive CL Model is an innovative solution to prevent or remove behavioral barriers that interfere with the quality and efficiency of medical care, has demonstrated reductions in length of stay and hospital costs, and improvements in patient outcomes and staff satisfaction. During the session, we will: 1) contrast the traditional CL model with the Proactive CL Model; 2) review the available data from several medical centers (Yale, Johns Hopkins, Dartmouth and Rochester) that have applied the Proactive CL model in adult medicine units; 3) discuss the conceptualization, adaptation and first implementation of the Proactive CL Model in a large pediatric hospital - the Ann & Robert H. Lurie Children's Hospital of Chicago and include a description of critical outcomes to be measured including length of stay, staff injuries, utilization of constant companion, and staff satisfaction. Lastly, we will discuss how the Proactive CL model will be adapted for use in a pediatric primary care clinic. This presentation will focus on how the Proactive CL model enhances integrated care in the pediatric medical home by refocusing the pediatrician on the identification of early risk factors for psychopathology, and empowers pediatricians to shift their focus from case identification by screening to identification of children and families at risk and the prevention and preemption of psychiatric disorders through behavioral and family focused interventions. The prevention and strategies discussed will be evidenced based therapeutic interventions adapted for use in busy pediatric primary care practices. Clinical vignettes and feedback from our pediatrician colleagues, trainees, and nursing staff will be used to demonstrate the process of implementation and full integration of the Proactive CL Model in pediatrics.

Psychiatrists in the #MeToo Era: Navigating Sexual Harassment Perpetrated by Patients

Chair: Christina M. Girgis, M.D.

Presenters: Syma Ali Dar, M.D., Gauri Khatkhate, Aparna Sharma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the commonality, scope and impact of sexual harassment by patients towards physicians and trainees; 2) Understand the

role of psychiatric illness within the context of sexual harassment by patients; and 3) Develop practical skills to address sexual harassment by patients when it occurs

SUMMARY:

Let's talk about #metoo. Sexual harassment and its deleterious effects in the workplace have been well recognized. Previous studies have found that anywhere from 44-76% of women physicians have experienced sexual harassment.¹⁻⁴ Female physicians who experience sexual harassment are more likely to experience lower career satisfaction and perceive gender bias in professional advancement.² Sexual harassment of physicians is widespread and begins as early as medical school, with 37.9-83% of medical students reporting sexual harassment during their education.^{1,5,6-8,9} Rates of sexual harassment during residency are also high, with 73-92.9% of resident physicians reporting at least one incident of sexual harassment during training, including unwanted physical advances, offensive body language, sexual comments, and unwelcome verbal advances.^{10,11,12} Female medical students and residents physicians are more likely than their male counterparts to report having been sexually harassed.^{10,11,6-8,9} Among those who have been harassed, almost half have reported that it creates a hostile work environment or interferes with work performance during training.¹⁰ Most studies indicate that the majority of female medical trainees do not report their experiences to an authority.^{10,11,12} Reasons that female trainees have given for not reporting sexual harassment include a lack of confidence that they would be helped, fear of retaliation, and feelings of shame or guilt.¹⁰ Though there is literature regarding sexual harassment of physicians by colleagues and supervisors, very few studies have focused on patients as perpetrators, which also has the potential for adverse effects.^{3,13} There is also limited information available about patients sexually harassing medical students and resident physicians. The data that exists, however, is concerning: one study found that 71% of female and 29% of male medical students reported at least one incident of inappropriate sexual behavior committed by a patient.⁶ One survey indicated that 75% of residents had experienced sexual harassment from patients as

compared to only 64% from colleagues.¹² Other studies have shown that compared to male medical students, female students experience rates three to four times higher of sexual harassment by patients.^{7,8} Frequently, the psychological effects of sexual harassment to medical trainees are emotional reactions of embarrassment, anger, and frustration.¹¹ Sexual harassment from patients can lead to significant consequences that impact not only the person receiving the harassment, but can negatively influence patient care as well. Given that this is an important topic with powerful implications, we would like to propose a workshop in which we educate psychiatrists and trainees about the scope of the problem, address how psychiatric illness can impact patient behavior in this context, and provide practical skills and strategies for how to manage this prevalent and impactful issue.

Psychiatry and the Duress Defense of Patty Hearst

Chair: Stephen G. Noffsinger, M.D.

Presenters: Adeyemi G. Marcus, M.D., Tetyana Bodnar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the conceptual basis of affirmative mental health defenses.; 2) Understand and apply legal standards for the duress defense.; 3) Demonstrate the ability to perform accurate duress defense evaluations.; and 4) Analyze the duress defense that Patty Hearst presented at her 1976 Bank Robbery trial that garnered international attention.

SUMMARY:

Duress is an affirmative defense to a criminal charge. The defendant pleading duress asserts that (s)he was coerced to commit the offense by the use, or threat, of unlawful force against his person or the person of another, such that a similarly situated person of reasonable firmness would have been unable to resist. A successful duress defense leads to an outright acquittal, even on serious violent charges. Duress is an infrequently raised but controversial defense, given that the successful duress defense leads to an acquittal. The prosecution and trial of Patty Hearst in the late-1970s, with several psychiatrists offering expert testimony regarding

Hearst's claim of duress, captured the county's attention. More recently, the Ohio Craigslist killings and subsequent duress defense of a youthful offender resulted in psychiatric expert testimony and controversy. Psychiatrists may be asked by courts, prosecutors or defense attorneys to evaluate a criminal defendant's duress defense. Evaluating duress is a unique exercise that requires examination of: the defendant's mental state and behavior at the time of the offense, vulnerability to coercion, relationship with person exerting coercion, consequences for failing to commit the offense, and other relevant factors. This workshop will present: 1. The history of the duress defense. 2. Statutory and case law regarding the duress defense. 3. Methodology to evaluate the duress defense. 4. Several duress vignettes with audience discussion. 5. Analysis of the Bank Robbery trial of Patty Hearst and the psychiatry testimony proffered regarding her duress defense. Audience participation will be achieved by randomly assigning attendees to one of three group roles (defense attorney, prosecutor, neutral expert witness). Several vignettes of actual and simulated duress cases will be successively presented. Groups will evaluate the vignettes from the perspective of their group role and argue for or against a duress verdict. Group roles will be rotated, giving each participant the opportunity to evaluate and advocate for each perspective in a duress defense case.

Psychiatry at the Border: Translating Between Politics and Medicine in the Trump Era

Chair: Eric Rafla-Yuan, M.D.

Presenters: Michael Henri Langley-Degroot, M.D., Deanna Rafla-Yuan, Adam Mehis

Discussant: Priti Ojha

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the changing landscape of US immigration and border enforcement policy with a particular focus on changes made by the Trump administration which impact medical and psychiatric outcomes.; 2) Recognize the significance of the current administration's changes to legislation and policy on immigration and enforcement as it relates to psychosocial stressors in California border communities.; 3) Identify the phenomenology of

psychiatric symptoms experienced and reported by patients in these border communities, as well as other manifestations observed by professionals who work with them.; 4) Critique the limits of medical interventions in targeting systemic challenges.; and 5) Appraise the utility of organized medicine and the role of mental health professionals in the political process and the establishment of effective public policy.

SUMMARY:

San Diego is one of the most active border regions in the United States, in 2017 hosting 67% of registered California-Mexico border crossings and 26% of registered US-Mexico border crossings. Additionally, California has historically hosted more refugees than any other state, with the largest amount being settled in San Diego County. Since 2017, the current administration has enacted sweeping changes to border and immigration policy, with notable examples including detention and forced separation of asylum-seeking families, the pursuit of undocumented individuals in hospitals and courthouses, a sharp decrease in acceptance of refugees, and new directives to revoke the US citizenship of those born near the US-Mexico border. These, along with the increased aggressiveness of Immigrations and Customs Enforcement (ICE), have affected many communities, and are especially pronounced in San Diego where these systemic changes have had measurable impacts on mental health and psychiatric symptomatology. The aim of this session is to give a multi-modal perspective on the translation of political change to psychiatric outcomes, and the role of the mental health professional in effecting change in these larger systems. We will start with a review of the changing landscape of immigration and enforcement policy. We will hear and critique challenges shared by multiple professions in working with distressed and vulnerable border communities. Specific case examples will be discussed, in which participants will identify how larger systemic changes directly translate into psychiatric symptoms or limit the ability to provide adequate psychiatric care. We will address the role of organized medicine and population-based approaches in improving quality and access to mental health care for all patients, with particular focus on the important role of mental

health professionals in the construction and advocacy of effective public policy. Panelists in the session will include the editor of the Stanford Journal of International Law, a governmental representative, the program coordinator of the UCSD psychiatry specialty clinic which serves undocumented patients, and psychiatric physicians and trainees who work in specialty programs serving torture survivors, asylum seekers, and refugees in the border regions of California.

Psychiatry in the Era of Quantum Biology

Chair: Donald Matthew Mender, M.D.

Presenters: Gordon Gary Globus, M.D., Mansoor A. Malik, M.D., Jack Tuszynski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the basic differences between non-quantum and quantum approaches to mind and brain; 2) Evaluate the relative advantages and disadvantages of moving from non-quantum to quantum frameworks for cognitive neuroscience; 3) Comprehend potential applications of existing quantum-cognitive and quantum-neurodynamical models to perspectives on psychopathology; and 4) Project possible future directions of innovation in psychiatric research based on quantum paradigms

SUMMARY:

A much discussed 2013 review article by Emmanuel Pothos and Jerome Busemeyer in Behavioral and Brain Sciences argued that quantum-probabilistic modeling captures many empirically known relations among human perceptions, including mutual interference, order-dependence, and non-localized links, more succinctly than does mainstream non-quantum probability. This suggestion has raised the possibility of a powerful new quantized enhancement of the classical psychophysics inaugurated during the 19th century by Ernst Weber and Gustav Fechner. In a development almost parallel to the Pothos and Busemeyer proposal, Gregory Engel's laboratory at the University of Chicago in 2007 demonstrated experimentally that photosynthesis, which occurs in the presence of intracellular water at ordinary biological temperatures, depends non-trivially upon quantum

components. This empirical finding, later amply replicated, has given rise to the now burgeoning discipline known as "quantum biology." Six years ago Columbia University's Werner Loewenstein, a principle early pioneer of now firmly established classical molecular research approaches to intercellular communication, extended quantum perspectives to cognitive neuroscience. The way for this reorientation had been paved by the work of physicists and other investigators who had previously proposed quantum-neurodynamical models based on hydrophobic macromolecular pockets, ordered intracellular water, pumped energy quanta, and linkages of quantized microtubular states to second messengers, membrane ion transport, and lipid raft chemistry. Over the past few years some of the nascent quantum-psychological and quantum-neurobiological ideas mentioned above and originally formulated to help account for normal neurocognition have also been enlisted as alternative lenses through which to revisit hypotheses concerning the genesis and nature of mental illness. Several efforts in this direction were undertaken by contributors from the University of California at Los Angeles and Irvine, the University of Helsinki, the University of Bologna, Florida State University, Umea University, Howard University, Yale University, and the University of Calgary. Resulting hypotheses have suggested relationships between psychiatric disorders and neuromodulatory influences on quantum-computable tubulin states, bulk Bohmian quantum potentials, quantum-statistical membrane ion channel signatures, and intraneuronal quantum phase transitions. The 2019 program, oriented toward psychiatrists without any technical background in physics beyond premedical course work, will explore and compare to mainstream non-quantum paradigms the strengths and weaknesses of abstract quantum-cognitive and concrete quantum-neurodynamical perspectives on normal and pathological mentation. No formal mathematics will be included.

Psychopharmacology in the Medically Ill

Chair: James Lloyd Levenson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Become familiar with specific

major risks of psychotropic drugs in a variety of medical conditions, and perioperatively; 2) Choose appropriate psychotropic drugs for specific medically ill patients; and 3) Identify alternative routes of administration for psychotropic drugs in patients who are NPO

SUMMARY:

This presentation will be a combination of didactics and individual cases. Basic principles of psychopharmacology in the medically ill will be briefly reviewed but the focus will be on practical advice for questions regarding prescribing psychotropic drugs in patients with significant organ impairment or other disease states including consideration of special risks. Examples include prescribing in patients who have had gastric bypass surgery; seizure disorders; Parkinson's disease; risk for QTc prolongation; renal insufficiency, etc.

Psychosurgery in the 21st Century: Evidence-Based or Biased?

Chair: Stanley N. Caroff, M.D.

Presenters: Andrew T. Scull, Ph.D., Robert J. Coffey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe historical examples of invasive psychiatric therapies that proved to be both ineffective and ethically questionable; 2) Identify current gaps in professional and regulatory oversight of psychosurgery that increase the risk of unchecked, untoward or abusive practices and research; 3) Understand the challenges to psychosurgical interventions presented by the state of diagnostic classification and management of behavioral disorders; 4) Interpret the results and limitations of recent research trials that investigated deep brain stimulation (DBS) and other psychosurgical procedures for behavioral disorders; and 5) Recognize the potential risks to patients, practitioners and the profession of premature and unwarranted adoption of psychosurgical procedures as routine medical care

SUMMARY:

Because behavioral disorders exact an enormous toll on patients, families, and society, the search for

better treatments is a public health priority. In pursuit of better therapies, people with behavioral disorders deserve the right to volunteer for experimental programs that offer hope of recovery for themselves and future generations. But the medical profession and society are obligated to apply the utmost scientific rigor and ethical safeguards to protect this vulnerable patient population. Transformative, breakthrough discoveries in brain research will undoubtedly lead to advances in treatment that may include surgical procedures or implantation of medical devices. But initial reports of the promise of psychosurgical procedures are often overstated while the risks associated with use or misuse are downplayed. For example, initial encouraging results using deep brain stimulation (DBS) for depression in case series were contradicted by two multi-center, randomized, controlled and blinded clinical trials. Despite these setbacks, promotion of this procedure has continued to appear unchallenged and unabated in the popular and scientific press, even extending its proposed reach to a broad range of unrelated disorders including dementia, traumatic brain injury, post-stroke paralysis, Tourette's syndrome, obesity, anorexia, substance abuse, and post-traumatic stress disorder. Public exposure of the limited evidence base for psychosurgery along with associated surgical, device, and therapy-related adverse effects could provoke a popular backlash that would have a chilling effect on other vital brain research and genuine advances in therapy. To broaden knowledge of the promise and perils of psychosurgery, we plan to review warnings from the past showing how moral leaders as early as the 15th century cautioned against oversimplified physical solutions to complex behavioral problems. Horrific abuses conducted under the guise of surgical research in the 20th century reveal the consequences of individual and system failures to prevent ineffective practices unsupported by transparency and critical analysis. Drawing on historical precedents, we plan to present a practice-oriented clinical review highlighting the many challenges and limitations of current research on psychosurgical procedures, focused primarily on DBS as a prototype. To facilitate debate and active discussion, the panel of experts in psychiatry, sociology, and neurosurgery, with first-hand experience in psychosurgery and oversight of DBS

clinical trials in psychiatry, will discuss historical and contemporary examples, challenging participants to use critical analysis to identify individual and system liabilities in ethical and scientific behavior. Ample time for questions and discussion will be allotted between presentations and at a general open panel discussion at the end of the session.

QI Made Ridiculously Simple: Harnessing Public-Academic Partnerships for Service Improvement

Chair: Andrea Elser

Presenters: Kate Benham, M.D., Robertino Lim, M.D., M.P.H., Robert Mendenhall, M.D., David Grunwald, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize importance of mental health services research projects in improving the delivery of patient care; 2) Summarize the components that make up simple mental health services research projects and the logistical limitations that constrain them; 3) Distinguish between quality improvement and research projects; 4) Identify best practices in how to develop academic and/or community partnerships; and 5) Generate ideas for feasible research projects that could be completed in your community setting by leveraging academic partnerships

SUMMARY:

Community mental health clinics are in dire need of well-trained psychiatrists who are both knowledgeable about the challenges facing public sector mental health services and equipped with the research skills necessary to enhance their clinics' level of care. This workshop will draw from experience gained through UCSF's Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital, the only public psychiatry fellowship in the country that features a mental health services research component as part of its curricula. Fellows provide clinical care at different public mental health clinics in San Francisco and, with help from faculty, design and implement a quality improvement project during their fellowship year. This year, our fellows will complete research projects examining engagement in wraparound services, linkage to vocational training, street psychiatry, and

telepsychiatry. Each of these will be completed with strong engagement and participation by our public partners. In this workshop, we will trace the history of quality improvement projects at specific clinical sites to highlight the contributions that even small-scale projects can make towards improving the delivery of patient care. We start with an overview of the process fellows go through to complete their research projects: identifying issues that challenge specific clinical sites, generating feasible methods to characterize the issue, and finally, suggesting possible applications of the results within the clinical site. Fellows will then briefly present their projects and findings. Time will be allotted to answering questions about the specific research projects as well as the general experience of completing the projects. We will then transition into collaboratively brainstorming ideas for projects that audience members may be interested in conducting in other public psychiatry fellowships or other clinical settings.

Quality Measurement With PsychPRO: MIPS and Beyond

Chair: Debra Gibson

Presenter: Diana Clarke, Ph.D.

Discussant: Gregory W. Dalack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Highlight PsychPRO's performance in its inaugural year in terms of CMS MIPS quality reporting and helping psychiatrists to meet MOC Part IV requirements; 2) Explore the use of PsychPRO in the implementation of quality measurement in a variety of practice settings; 3) Highlight the use of PsychPRO as a quality improvement tool and its use in facilitating measurement-based care; 4) Briefly detail PsychPRO's, as a CMS QCDR, involvement in quality measure development; and 5) Discuss challenges in quality measurement including, what to measure and how to go about measuring it

SUMMARY:

Quality of care and cost containment issues have put a spotlight on patient outcomes with questions being asked about appropriate types and levels of care associated with variation in medical practice. As

such, clinicians' interest in obtaining objective information about their practices has increased, and patients and purchasers want to know more about the quality of care available and patient outcomes. Measurement-based care (MBC), the routine use of standardized tools or instruments to monitor the individual's progress in achieving his or her care, treatment, or service goals; is identified as an appropriate and necessary part of the culture of mental health care and systems. The standardization of MBC requires innovative tools that are clinically useful, easy to use, and feasible to implement in clinical practice. PsychPRO, the APA's qualified clinical data registry (QCDR), with its patient and clinician portals, provides the opportunity for participating psychiatrists and other behavioral health clinicians to implement MBC, monitor the quality of care they provide to their patients, and continuously improve their practice. Further, participation in PsychPRO, helps the field of psychiatry by putting the development of quality measures that impact the practice of psychiatry into the hands of psychiatrists. This current session is designed to 1) highlight PsychPRO's performance in its inaugural year in terms of quality reporting and helping psychiatrists to meet MOC Part IV requirements; 2) explore the use of PsychPRO, in the implementation of quality measurement in a variety of practice settings; and 3) highlight the use of PsychPRO as a quality improvement tool and its use in facilitating MBC as well as quality measure development. We will discuss challenges including, what to measure and how to go about measuring it.

Quelling Obsessive Thoughts: OCD Medication, Therapy and Brain Stimulation Advances

Chair: Carolyn Rodriguez, M.D., Ph.D.

Presenters: Jamie D. Feusner, M.D., Lorrin M. Koran, M.D., Nolan Williams, Stefano Pallanti, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To review APA OCD Treatment Guidelines and challenging cases; 2) To review APA OCD Treatment Guidelines and challenging cases; 3) Review recent data on mechanisms of novel therapeutics; 4) Present data on non-invasive brain stimulation and co-morbid depression; and 5)

Discuss international collaborative efforts and definition of recovery

SUMMARY:

Standard first-line treatments for OCD may not provide sufficient relieve of OCD symptoms for all those seeking care; thus, there is an urgent need for alternative treatments. This symposium will summarize recent work in novel medication, therapy, and brain stimulation for those considering future treatment options. The format will be a series of 5 interactive presentations (interactive audience survey/polling and eliciting questions/cases from the audience) followed by a panel/Q and A session. Specific new research studies will be presented as follows: Dr. Carolyn Rodriguez will review current APA OCD treatment guidelines and present her research studies on rapid-acting, novel therapeutics that act through glutamate, GABA, and opiate pathways. Dr. Jamie Feusner will describe new findings regarding the neural mechanisms of intensive cognitive-behavioral therapy (CBT) for OCD, as demonstrated by large-magnitude changes in resting state brain connectivity patterns from pre- to post-treatment. In addition, he will describe how functional connectivity patterns from neuroimaging can be used to predict individual patients' post-CBT OCD symptom outcomes using machine learning. Dr. Lorrin Koran will present on promising novel drug treatments that require further investigation and discuss advanced pharmacological strategies for difficult to treat OCD cases elicited from the audience. Dr. Nolan Williams will review non-invasive brain stimulation in OCD, including the recent FDA approval and present his new research studies on novel, rapid-acting brain stimulation for co-morbid depression. Dr. Stephano Pallanti will review his collaborative research through the International College of Obsessive-Compulsive Disorders (ICODS) and his recent work on the dimensions and definition of recovery in OCD.

Racism and Psychiatry: Achieving Health Equity for Minority Communities Through Faith-Based Partnerships

Chair: Morgan M. Medlock, M.D., M.P.H.
Presenters: Danielle Hairston, M.D., Ayana Jordan, M.D., Ph.D., Christine Crawford, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the potential impact of spiritual/religious involvement on the mental wellbeing of racial minorities.; 2) Describe programmatic elements of faith-based partnerships for engaging minority communities in behavioral health care.; and 3) Conceive three strategies for helping spiritual/religious clients utilize mental health services provided by faith-based organizations.

SUMMARY:

This workshop is informed by the content of the recent volume, *Racism and Psychiatry: Contemporary Issues and Interventions* (Medlock et al, eds., 2018). Presenters will discuss the role of faith-based organizations in helping members cope with the psychosocial and health effects of racial discrimination. The role of the church as an effective buffer against racism is especially relevant to the mental health care of African Americans, who are the most religiously involved ethnic group in the US. Attention will be given to highlighting contemporary faith-based efforts to improve minority mental health. After underscoring outcomes relative to these interventions, strategies for providers and faith leaders to link religious supports with formal mental health services will be discussed.

Redesigning Psychiatry: Innovative Models of Mental Health System Change

Chair: Jean-Marie E. Alves-Bradford, M.D.
Presenters: Gary Belkin, Margaret E. Balfour, M.D., Ph.D., Itai Danovitch, M.D., M.B.A., Toby Ewing, Barry David Sarvet, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand current gaps in mental health care delivery systems; 2) Describe two key components of each of the multisystem models of mental health system change presented; and 3) Identify two or more opportunities to effect change in the mental health care system

SUMMARY:

One in five adults in America experience mental illness in a given year.¹ Nearly 60% of adults and

50% of children with a mental illness didn't receive mental health services in the previous year.² Limited access to adequate mental health treatment has devastating social and emotional impact including increased disability and costs of \$193.2 billion in lost earnings annually.³ Although many research studies demonstrate the efficacy of various clinical interventions, large scale change to the health care delivery system is required to ensure high quality mental healthcare actually reaches the people who need it the most. The Panel will describe the work of four large-scale initiatives which are transforming systems of mental health care. The session will explore similarities and differences in the strategies employed by these initiatives with the aim of addressing disparities in mental health care through multi-level interventions. We will facilitate a panel discussion in which the audience can discuss ways to catalyze system change in their own communities. The goal of the session is to outline the lessons learned from these innovative models and to stimulate discussion regarding solutions to ongoing challenges in achieving mental health equity across diverse contexts. City Level Initiative: In November 2015, First Lady Charlene McCray launched the ThriveNYC initiative, an unprecedented effort to leverage the unique opportunities of city-led change for a comprehensive public health approach to mental health in New York City. To date, this initiative has led to the development of 54 citywide initiatives encompassed by six guiding principles, with a range of promising outcomes.⁴

*Regional/State Level Initiative: The Southern Arizona Crisis System leverages local, state, Medicaid, and other federal funds to create a coordinated system of care that includes a robust crisis continuum⁵. The system's financing and governance structure supports collaborative efforts to achieve strategic goals, such as reducing criminal justice involvement and stabilization in the least restrictive community settings⁶. *State Level Initiative: In 2004 large scale public mental health system change in California began when voters passed Proposition 63: The Mental Health Services Act (MHSA).⁷ This increased taxes by 1% on every dollar of taxable net incomes over \$1million, and the money was restricted for use to improve mental health services for people with or at risk of a mental disorder. The Mental Health Services Oversight and

Accountability Commission was created to oversee the implementation of the MHSA and develop strategies to overcome stigma.⁸ *National Level Initiative: In 2011, a core group of national leaders established the National Network of Child Psychiatry Access Programs which supports existing and emerging child psychiatry consultation programs and works to further national progress toward effective integration of mental health with primary care.

Reducing Health Disparities Through Measurement-Based Care: Opportunities to Improve Outcomes in Serious Mental Illness

Chair: Soren D. Ostergaard, M.D., Ph.D.

Presenters: Christoph U. Correll, M.D., John Michael Kane, M.D., Soren D. Ostergaard, M.D., Ph.D., John Torous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize how technology-enabled, measurement-based care can reduce health disparities through increasing quality and standardization of care.; 2) Assess the potential and readiness of your practice for using measurement-based care to reduce health disparities.; and 3) Provide three examples of measurement-based care scales and tools you can use with your patients today.

SUMMARY:

The reality of health disparities in patients with serious mental illnesses can no longer be ignored. One piece of the solution for offering the best care for these patients is the implementation of measurement-based care and services. This session will address the key issues in understanding the current state, new developments, and practice-ready insights that psychiatrists can utilize to begin implementing measurement-based care today. The session will focus on health disparities and offer practical solutions for ensuring these new tools and care models will benefit all patients. The session consists of four presentations followed by a question & answer period: In the opening presentation, Dr. Christoph U. Correll will frame the opportunities for measurement-based care to reduce health disparities. Dr. Correll will provide an overview of measurement-based care, cite examples from the

medical field and depression management, and raise relevant questions for the area of schizophrenia, including the promise for reducing health disparities, and designs to test the effectiveness and cost utility of measurement-based care for patients suffering from serious mental illnesses. In the second talk, Dr. John M. Kane will illustrate how new tools may bring measurement-based care to traditionally disenfranchised populations, and quantify the lived experiences of those with serious mental illness. Specifically, this talk will outline the development, design, implementation, application and results of a computerized decision support tool “COMPASS” that was embedded in the NIMH-funded, cluster-randomized Recovery After an Initial Schizophrenia Episode (RAISE) trial. The talk will focus on how this new tool can be used to reduce health disparities today. The third presentation will focus on whether a six-item version of the Positive and Negative Syndrome Scale (PANSS-6) can enable measurement-based care in schizophrenia. This talk will outline the creation of new scales with a focus on ensuring their validity in populations experiencing health disparities. Specifically, Dr. Soren D. Ostergaard will present findings from three different studies, one unpublished, that tested different versions of, finding that the brief PANSS-6 version tapping into six core positive and negative symptoms was the only psychometrically valid PANSS-version. Finally, Dr. John Torous will illustrate why successful measurement-based care interventions must involve support and buy-in from patient communities as well. This talk will focus on how populations experiencing health disparities, such as those with schizophrenia, understand and use self-tracking and reporting tools like smartphones and smart watches. Drawing on clinical examples, survey data, and interactive cases, this talk will outline best practices for implementing measurement-based care. The session will be concluded by an interactive question & answer period.

**Reevaluating and Redefining Supervision:
Challenges for 21st Century
Psychiatrists**

*Chairs: Robert Scott Nesheim, M.D., Edmund Grant
Howe, M.D.*

Presenter: Sheila Hafter Gray, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Differentiate goals of supervision for education, quality assurance review, adherence to research protocols.; 2) Reassess their models of supervision in light of 21st century ethical principles; and 3) Implement a model of clinical supervision that unifies support for the development of autonomous, fully professional psychiatrists with respect for the primacy of their patients.

SUMMARY:

In current usage, supervision — oversight — is a term that refers to a broad range of activities: monitoring attendance, assuring appropriateness of care by semi-professional health care workers, assessing fidelity to manual driven therapies, facilitating acquisition of new skills by a range of health care professionals, and more. Supervising psychiatric work poses specific ethical and technical challenges at each level, from undergraduate medical education through residency and fellowship to autonomous practice. Supervisors are increasingly responsible for the safety of both patient and trainee, and for providing optimal — or averting suboptimal — care. They may also be required to support the values and aims of the health care system in which they work, and to help resolve ethical conflicts that may arise within those organizations. In each situation, they must counterbalance these demands with assuring that trainees are provided enough opportunity to learn by experience, including the experience of learning from their mistakes, and confronting and mastering temptations to cross or violate boundaries. Traditional models of supervision tend to prioritize one aspect of the supervisor-trainee-patient relationship over others, leading to conflicts of commitment that may be resolved only by sacrificing primacy of the patient or educational needs of the trainee, or both. In this workshop we will examine current models of supervision as they evolved over time. Faculty and participants together will consider: (1) Which classic views of supervision conflict with, or support, the development of a new generation of autonomous, fully professional, psychiatrists? (2) Can these traditional models be implemented while adhering to 21st century ethical principles, particularly in respect of the autonomy

and primacy of individual patients? (3) May we develop a unitary concept of supervision that is appropriate across the spectrum of situations in which psychiatrists work? (4) How may we implement our personal and professional ideals within the structures of contemporary health care and medical education? Disclaimer: The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as necessarily reflecting the views or policies of the Armed Forces Radiobiology Research Institute, the Uniformed Services University of the Health Sciences, or the Department of Defense. The funders had no role in study design, data collection, and analysis, decision to publish, or preparation of the manuscript. Conflicts of interest: None

Refugees, Immigrants and Asylum Seekers: Mental Health, Advocacy, and Human Rights

Chair: Hossam M. Mahmoud, M.D., M.P.H.

Presenters: Lise Conway Van Susteren, M.D., Maria Jose Lisotto, James Lee Fleming, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand factors contributing to mass migrations, defining asylum seekers, refugees and immigrants; 2) Appreciate the mental health effects of separation and trauma on adults and on children's development, attachment, future relationships and intergenerational trauma; 3) Review geopolitical changes and migration, as well as efforts of human rights' and advocacy groups; 4) Discuss a comprehensive strategy that includes education, advocacy, partnerships and service provision for asylum/refugee seekers; and 5) Highlight the roles psychiatrists can have in healthcare provision, mental health advocacy and human rights promotion

SUMMARY:

Over the past few years, the world has been witnessing large mass migrations, rarely seen in human history. These mass migrations are caused by war and other forms of armed conflicts, crime and resulting violence, human rights violations, extreme poverty, climate change and natural disasters. These factors have given rise to ever-increasing numbers of internally displaced persons, refugees, asylum

seekers, migrants and climate refugees. In addition to the physical displacement, these migrations lead to cultural dislocation, feelings of alienation and experiences of perpetual re-traumatization. The mental health consequences of the traumas of displacement, cultural dislocation and family separations have been well-documented in children, adolescents, adults and families. These consequences go well beyond post traumatic stress disorder, depression and anxiety disorders, and include devastating effects on development, attachment, adjustment and overall well-being of present and future generations. This session will discuss different aspects of forced migration. First, we discuss key concepts and definitions related to forced migration, the contributing factors, perpetuating factors and mitigating factors. Next we discuss the mental health sequelae of the trauma associated with forced displacement and of family separations on children, adolescents, adults and families, including the effects on development, attachment, adjustment and overall well-being. We also discuss some diagnostic and clinical challenges that clinicians face when working with refugees, asylum seekers and other forcefully displaced populations. Then we present first hand witness report of life in refugee camps, including the conditions in the camps and the associated physical and mental health toll of living in such conditions. We also discuss climate change and the different ways in which it is threatening the way of life of many populations around the world, contributing to the emergence of climate refugees. We end with a panel discussion that highlights the different roles psychiatrists can play to help address the current global crises, as clinicians providing mental health services, as thought leaders and educators, and as human rights and social responsibility advocates. The discussion will also cover present and potential opportunities available for psychiatrists and other mental health professional to volunteer and work with displaced populations.

Revising the DSM: An Update on Changes From the DSM Steering Committee

Chair: Paul S. Appelbaum, M.D.

Presenters: Roberto Lewis-Fernández, M.D., Charles F. Reynolds, M.D., B. Timothy Walsh, M.D., Carlos Blanco-Jerez, M.D., Ph.D., Michael B. First, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the process by which changes can be made to the DSM;; 2) To have a grasp of the criteria applied to different types of proposals for change;; and 3) To discuss the positive and negative factors associated with several specific proposals, as examples of decision making about modifications to the DSM.

SUMMARY:

Following the publication of DSM-5, the American Psychiatric Association established a process whereby changes could be made that pertain to specific diagnostic categories, as evidence supporting such changes becomes available. Possible modifications include changes to an existing diagnostic criteria set; addition of a new diagnostic category or specifier; deletion of an existing diagnostic category or specifier; corrections and clarifications applicable to the diagnostic criteria; and changes to the text of the DSM. Proposals for changes and supporting data are solicited from the field. The DSM Steering Committee oversees the process of reviewing proposals, with five Review Committees tasked with making recommendations regarding proposals, each responsible for a broad area of psychiatric diagnosis. At this session, Dr. Appelbaum, the chair of the DSM Steering Committee, will summarize the procedures that have been established, after which four review committee chairs will describe the content of one proposal and the process used to evaluate its scientific merit. Dr. Lewis-Fernandez, chair of the Internalizing Disorders Review Committee, will describe his group's work on a proposal for a new DSM diagnosis of persistent grief disorder; Dr. Walsh, member of the Body Systems Disorders Review Committee, will address his group's consideration of a change to the criteria for Avoidant/Restrictive Food Intake Disorder (ARFID); Dr. Blanco, chair of the Externalizing and Personality Disorders Review Committee will discuss his group's review of a proposed text change for pedophilic disorder; and Dr. First, chair of the subcommittee

dealing with minor changes, will illustrate one or more of the changes reviewed by his group. Attendees will be encouraged to comment on the proposals and the process of review, and the presenters will attempt to answer any questions.

Scaling Behavioral Health Integration: One Academic Health Care System's Approach

Chair: Sabina Lim, M.D., M.P.H.

Presenters: Rajvee P. Vora, M.D., Kimberly Klipstein, M.D., Hansel Arroyo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify benefits and challenges of different integrated practice models; 2) Discuss and identify key measurable outcomes for integrated practices; and 3) Understand how one system's approach to scaling integrated behavioral health

SUMMARY:

The integration of behavioral health services with primary care and specialty care services has significant rewards for patients and providers, yet can be operationally challenging to implement and sustain at the individual practice level. To have the greatest impact, integration must also occur on a large scale and across multiple settings and patient populations. The Mount Sinai Health System in New York currently has 18 integrated practice sites, ranging from basic co-location to advanced integration models in primary care, as well as reverse integration of primary care services in behavioral health. Sites span the full age range (child, adult, geriatric) and across multiple physical health care settings (inpatient and outpatient; primary care to hepatology to HIV/AIDS centers). We will discuss the overall approach and design of integrated behavioral health services in our health system, how we obtained buy-in to scale services, and how we tailored the type of integrated care model to different sites. We will present preliminary performance data for different sites, and discuss ongoing challenges at both the individual practice site and at the system level. We will then actively discuss and brainstorm with the audience, with audience members bringing forth real-life challenges in building and running integrated practices, and

both audience and presenters actively brainstorming to identify solutions. Challenges can be tailored to the audience's needs, and/or we will go through 3 pre-identified issues: 1) identifying the most appropriate integrated care model for your practice; 2) Getting true buy-in from host practices (and from leadership); 3) Handoffs/workflow issues.

Separating Parents and Children: Impact on Mental Health and Resilience

Chairs: Rachel Yehuda, Ph.D., Adriana Feder

Presenters: Rachel Cardon Kronick, M.D., M.Sc., Alicia Lieberman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide relevant examples of separation trauma; 2) Understand the impact of early separation on children and families; 3) Identify appropriate clinical approaches for treatment of separation trauma; and 4) Consider the impact of current events on children and families

SUMMARY:

This session will present the latest research information regarding the impact of early separation on children and families, as well as a discussion of best clinical practices for children and adults affected by separation trauma. Audience participation will ensure discussion of how to apply material to clinical cases. Dr. Rachel Yehuda will provide an overall introduction emphasizing the early childhood as a critical window of opportunity for developmental plasticity, and attachment behavior as a major conduit for promoting later mental health and resilience. Dr. Adriana Feder will briefly present an outline of resilience-related studies on the impact of childhood trauma that are ongoing at the Adolescent Health Center at the Mount Sinai Hospital. Dr. Angela Diaz, Director of the Mount Sinai Adolescent Health Center, will discuss the clinical presentation of inner city teens and their implications on mental and general health that have led to these recent studies and health initiatives in the community. Dr. Rachel Kronick, child and adolescent psychiatrist at McGill University, will present recently published research on refugee and asylum-seeking in children who are separated from parents in the context of immigration detention in

Canada. Dr. Alicia Lieberman, an attachment and trauma clinical researcher, will discuss results of treatment studies with parents and very young children, including infants. As separations from parents continue to be a relevant issue for immigrants, refugees and some vulnerable populations, understanding and treating the clinical consequences of migration and other policies that impact family unity is critical for the practicing mental health professional.

Supporting Physicians and Trainees With Mental Illness and Substance Use Disorders

Chair: Tamar C. Carmel, M.D.

Presenters: Frank A. Clark, M.D., Michelle Georges, M.D., Robert Dean Davies, M.D., Doris C. Gundersen, M.D., Tamar C. Carmel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the risk/benefits/vulnerabilities of self-disclosure in the workplace; 2) Identify how training programs can support residents and fellows with mental illness and/or substance use disorders; and 3) Identify ways that organizations and systems of care can help and advocate for trainees and physicians with mental illness and substance use disorders

SUMMARY:

As we know, approximately 20% of Americans experience mental illness and approximately 15% experience substance use disorders in a given year. Despite increased education around such, medical trainees and physicians remain subject to the same societal stigma as well as professional stigma around mental illness and substance abuse. In fact, the prevalence of depression in medical students is approximately 25-27.2%, in medical trainees 20.9-43.2%, and in physicians as a whole 13-20%. The physician suicide rate is alarmingly high, over double the rate of the U.S. population as a whole, affecting 300-400 physicians per year. The prevalence of alcohol use disorders in physicians is difficult to accurately assess, but at the low range is estimated to be 12.9-21.4%, limited by poor physician response to the study surveys. Disordered alcohol use was found to be associated with various factors including physician burnout, depression, suicidal ideation, and

recent medical errors. This symposium will explore the varying personal, racial and cultural, professional, and systemic reasons impacting physicians' access to care or determination to not seek out care for mental illness and substance use disorders. Further, this session will explore ways that programs, organizations, and systems can better support and advocate for trainees and physicians with mental illness and/or substance use disorders. This symposium is a continuation of the session last year entitled: "Psychiatrists in Recovery: What Should I Say? What Should Be Done? Disclosing Our Experiences with Mental Illness and Emotional Suffering," utilizing attendees' feedback for a more nuanced discussion of how to better support those with mental illness and substance use disorders in our ranks.

Tardive Dyskinesia: A Primer for Resident Physicians: Diagnosis, Epidemiology, Etiology, Neurobiology, and Treatment

Chairs: Richard Calvin Holbert, M.D., Uma Suryadevara, M.D.

Presenters: Dawn-Christi M. Bruijnzeel, M.D., Maanasi H. Chandarana, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the diagnosis of Tardive Dyskinesia; 2) Review the incidence and prevalence of Tardive Dyskinesia; 3) Recognize medications that cause Tardive Dyskinesia and their relative risk; 4) Summarize the neurobiology of Tardive Dyskinesia; and 5) Identify treatment options for Tardive Dyskinesia

SUMMARY:

Tardive Dyskinesia (TD) is a movement disorder caused by the use of dopamine blocking agents. It is a chronic, disabling condition which frequently leads to social and occupational dysfunction. Most cases of TD are seen in patients with Schizophrenia or Schizoaffective Disorder but it is also seen in patients with other disorders who receive antipsychotic medications. Approximately 20-50% of those treated chronically with antipsychotics will develop TD. With the ever-increasing use of antipsychotics, this prevalence will rise. Second generation antipsychotics are associated with a lower risk of

developing TD compared to the first generation antipsychotics. DSM-5 provides diagnostic criteria for TD. We will review these criteria and discuss available rating scales to assist in making a definitive diagnosis. During the session, we will talk about the most recent incidence and prevalence data related to TD, review all medications that cause TD and review the relative risks of different antipsychotics that cause TD. Multiple neurobiological mechanisms proposed including postsynaptic dopamine receptor sensitivity, dysfunctional striatal GABAergic neurons, maladaptive synaptic plasticity, and neurodegeneration will be summarized. The last portion of the session will focus on management of TD. This will include the current FDA approved medications (valbenazine and deutetrabenazine), and the non FDA approved treatment options including clozapine, typical antipsychotics, atypical antipsychotics, amantadine, piracetam, levetiracetam, clonazepam, ginkgo biloba, and other innovative strategies. We will discuss the dilemma faced by psychiatrists frequently: patients requiring medications for their symptoms and yet the medication causing the disabling symptoms. A number of case examples will be provided to assist in the diagnosis and treatment. The session leaders have significant experience treating patients with TD and are published in this area. Participants will monitor their progress using pre and post session examinations. There will be an open forum to answer questions.

Teaching Psychiatry Residents About Autism Spectrum Disorder and Intellectual Disability

Chairs: Roma Vasa, M.D., Kathleen A. Koth, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. To recognize the need to strengthen psychiatry training in the care of individuals with autism spectrum disorder (ASD) and intellectual disability (ID); 2) 2. To present two training resources on ASD/ID, educational videos and clinical vignettes, that training directors can implement at their respective institutions in order to teach psychiatry resident; and 3) 3. To engage training directors in a discussion about the strengths and weaknesses of these training tools, as well as

potential strategies to improve psychiatric training in this area

SUMMARY:

The 21st century has brought significant challenges in the care of individuals with ASD and ID. Both ASD and ID are prevalent neurodevelopmental disorder, with ASD affecting 1 in 59 children (Baio et al., 2018) and ID affecting approximately 1% of the population (Maulik et al., 2011). Each disorder is associated with significant co-occurring psychopathology yet there are very few general and child psychiatrists with adequate training to treat these populations. This practice gap was first documented in 1991 when the American Psychiatric Association Task Force reported that 96% of state institutions for individuals with ID had difficulty hiring a psychiatrist (Szymanski et al., 1991). Insufficient training in ASD/ID was cited as the main obstacle to hiring. Now, over 25 years later, Marrus et al. (2014) demonstrated that the problem of inadequate psychiatry training in ASD/ID continues. In a survey of general and child psychiatry training directors, Marrus et al. (2014) reported that training programs currently offer an average of 7 hours of lectures on ASD/ID, and exposure to 1-5 psychopharmacology cases per year. Program directors indicated that obstacles to training include a shortage of experts, specialized developmental disabilities services, and funding within their respective institutions. These findings indicate the persistence of educational gaps in ASD/ID training. It is therefore critical that we pursue efforts to train psychiatry residents to care for these populations. The Training Workgroup of the AACAP Autism and Intellectual Disability Committee has been charged and funded (through an AACAP grant) to draft a curriculum and training resources that can be disseminated to training directors to implement at their respective programs. The proposed workshop will present two components of this curriculum, educational videos and clinical vignettes. These are described below: 1. Educational videos: Nine educational videos were developed by Training Workgroup members and the content was reviewed by national experts in the field. The videos focus on a range of topics including assessment (ASD, ID), genetic testing, psychopathology, psychopharmacology, educational and transition processes, behavioral interventions, multidisciplinary

services, and office-based practice tips. At the end of each video, there is a question-answer session with a moderator, which focuses on how to help residents apply the content to clinical practice. 2. Clinical vignettes: The vignettes include a wide variety of cases of individuals with ASD/ID across the lifespan (e.g., child, adolescent, transition age, adult). The individuals have varying developmental, medical and psychosocial challenges (e.g., comorbid seizures, genetic conditions, etc.). Each vignette is accompanied by 3-5 clinical questions for the trainee and an answer key for the attending physician that includes the main teaching points.

The Argument for Suicide-Specific Diagnoses in the DSM

Chair: Maria Antonia Oquendo, M.D., Ph.D.

Presenters: Maria Antonia Oquendo, M.D., Ph.D., Thomas Joiner, Igor I. Galyanker, M.D., Ph.D., Skip Simpson

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will be able to describe the features of suicide-specific disorders, including differentiating them from mood disorders and explaining them to patients.; 2) At the conclusion of this session, participants will be able to explain the evidence supporting suicide-specific diagnoses in the DSM.; 3) At the conclusion of this session, participants will be able to understand the course and outcome of proposed suicide-specific disorders.; and 4) At the conclusion of this session, participants will be able to articulate principles for management of safety, ethical, and legal issues in patients with proposed suicide-specific conditions.

SUMMARY:

Despite the extremely high global prevalence of suicide, none of the DSM editions have included a suicide-specific diagnosable condition. Since the DSM provides a standardized system and language for classifying psychiatric conditions to inform care, research, education, and public policy, suicide-specific diagnoses may be crucial in lowering suicide rates and reducing the personal and societal burden of suicide. Given that suicide-specific conditions have not been included

over the several decades of the DSM effort, an argument for their inclusion is consistent with the overall conference theme of “Revitalize Psychiatry,” including the theme’s keywords of “Disrupt,” “Include,” “Engage,” and “Innovate.” Two arguments exist for including a suicide-specific diagnosis in the DSM. The first is that although suicide often occurs in the context of psychiatric conditions, this is not invariably so. In the recent CDC analysis of all suicide deaths in the US, more than half of suicide decedents did not have a diagnosable mental health condition. Although many undiagnosed decedents surely had undetected conditions, it is quite possible that some would have met criteria for no disorder other than a suicide-specific one. Second, suicide is a transdiagnostic lethal outcome that co-occurs with a vast array of psychiatric conditions. However, our current nosology includes suicidal ideation and suicide attempts as symptoms, with the unfortunate potential implication that suicide and suicide prevention are not central concerns in our treatment. Three suicide-specific diagnoses have been identified to date. Suicidal Behavior Disorder (Oquendo & Baca Garcia, 2014) applies to individuals who have made a suicide attempt within the past two years and is listed in DSM-5 as a condition for further study. The Suicide Crisis Syndrome (SCS, e.g., Galykner et al., 2017) and Acute Suicidal Affective Disturbance (ASAD, e.g., Rogers et al., 2017) describe an acute pre-suicidal mental state, and are not yet listed in the DSM-5. This symposium will provide an overview of the phenomenology and existing empirical evidence for the Suicidal Behavior Disorder, ASAD, and SCS, as well as outline a number of future research directions, and crucially, present legal issues regarding the inclusion of suicide-specific diagnoses in DSM. As such, the symposium will be a call to action for more research on these syndromes and serious consideration of their featuring in future versions of nomenclatures. Drs. Oquendo, Joiner, and Galykner – thought-leaders regarding these syndromes and practiced at audience engagement on this topic – will discuss Suicidal Behavior Disorder, ASAD, and SCS, in turn. Mr. Simpson – an attorney specializing in mental health malpractice, especially cases involving a death by suicide – will add the legal perspective on the

necessity and consequences of having suicide-specific diagnoses in the DSM. An interactive Q&A with the panelists will conclude the symposium.

The Challenges of Treating Obesity and Comorbid Binge Eating

Chair: Debra L. Safer, M.D.

Presenters: Susan Lynn McElroy, M.D., Shebani Sethi Dalai, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand differing perspectives between obesity and eating disorder specialists regarding targeting weight loss in obese binge eaters; 2) Review evidence for addressing both binge eating and weight among obese binge eaters using: cognitive behavioral therapy, behavioral weight loss, nutrition management, and integrated approaches; 3) Describe the impact of lisdexamfetamine dimesylate from randomized trial data on both binge eating and weight among individuals with comorbid binge eating disorder and overweight/obesity; and 4) Describe the impact of phentermine-topiramate-ER from a recently completed randomized trial on both binge eating and weight among individuals with binge eating disorder/bulimia nervosa

SUMMARY:

Many individuals with obesity and disordered eating present to their clinicians with the desire to lose weight, yet there is no agreed upon treatment for obesity and comorbid binge eating. The session will begin with an overview of differing perspectives from the fields of obesity and eating disorders when treating individuals with these comorbid conditions. This first presentation will also review weight and eating disorder outcomes from research studies utilizing cognitive behavioral therapy, behavioral weight loss, nutrition management, and combined psychotherapy and pharmacotherapy approaches with obese binge eaters. The use of lisdexamfetamine dimesylate, a CNS stimulant, will be discussed in the next presentation. This medication has been shown, using randomized controlled trials, to significantly reduce both binge eating and weight and is the only FDA approved

medication for moderate to severe binge eating. Its leading researcher will present evidence her group has obtained in recent years. The last speaker will present promising results from a recently completed randomized trial investigating the combination of phentermine-topiramate ER on both binge eating and weight among individuals with binge eating disorder and bulimia nervosa. To promote maximal audience participation and application to clinical practice, illustrative case vignettes will then be posed. Audience members will break into small groups using the vignettes to discuss the pros and cons of different treatment options for individuals with obesity and comorbid binge eating. The session will conclude with time for moderated discussion/question and answer between the audience and speakers to address the vignettes and the presentations.

The Essential Role of Mental Health Professionals in Securing Equality for LGBTQ People

Presenter: Shannon Minter, Esq.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to identify the role of mental health professionals in key court victories for LGBT people.; 2) At the conclusion of this session, the participant will be able to identify the key role of mental health professionals in key legislative victories for LGBT people.; and 3) At the conclusion of this session, the participant will be able to identify challenges to both LGBT equality and science.

SUMMARY:

Medical science, including knowledge and research about human psychology and mental health, has played an essential role in securing equality for LGBT people in the U.S. From early challenges to sodomy statutes to more recent efforts to challenge attempts to ban transgender people from military service, courts have relied heavily on expert testimony by medical and mental health professionals to rebut false information and unfounded stereotypes. Such expert knowledge has played a similarly central role in legislation, including laws that protect LGBT youth from conversion

therapy. In the face of new attacks on both LGBT people and science itself, it is more critical than ever than legal advocates and mental health professionals work together to combat bias and to ensure that courts and legislators have access to reliable, well-founded information about sexual orientation and gender identity.

The History of American Psychiatry and of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Communities

Chair: Howard Charles Rubin, M.D.

Presenters: Margery S. Sved, M.D., Saul Levin, M.D., M.P.A., Robert Paul Cabaj, M.D., Curley L. Bonds, M.D., Adrian Jacques H. Ambrose, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; and 3) Identify barriers to care, including health service delivery issues

SUMMARY:

The history of American psychiatry and of lesbian, gay bisexual, and transgender (LGBT) Americans are inextricably tied together. As the American Psychiatric Association (APA) celebrates its 175th anniversary, it is important to reflect upon that relationship and examine the crucial role APA played in the transformation from the criminalization and stigmatization of homosexuality to its celebration, from the debate about the validity of the illness model of homosexuality, to its depathologization in 1973, and APA's advocacy for LGBT patients and psychiatrists and support for gay marriage. This presentation will explore those relationships in depth. Dr. Robert Cabaj, Chair of Psychiatry, Medical Director, San Mateo County Behavioral Health and Recovery Services, will provide an overview of the movement's progress in the past 50 years. He will describe the emergence of LGBT affirmative psychiatry and how psychotherapeutic issues have evolved. Dr. Saul Levin, president and CEO of the APA, will illustrate organized psychiatry's role in the struggle for LGBT rights with a presentation about Dr. Anonymous, John Fryer, MD, who dared to speak

out as a gay psychiatrist, but wore a mask to hide his identity at a panel discussion at the APA in 1972. The history of LGBTQ psychiatrists of color remains largely untold, due in part to the “double discrimination” and stigma that members of underrepresented minority groups often face if they choose to come out publicly. Dr. Curley Bonds, Chief Deputy Director, Clinical Operations for the Los Angeles County Department of Mental Health, will cover the contributions of a few notable LGBTQ psychiatrists of color and some of the issues they face that set them apart from their non same-gender-loving peers. Margie Sved, MD, the second lesbian AGLP president and a long standing LGBT representative to the Assembly MUR Caucus will review the history of lesbians within APA and AGLP, including a focus on family issues. Guiding the conversation about the contemporary challenges in LGBTQ mental health, Dr. Jacques Ambrose, member of the Advisory Committee on LGBTQ issues to the AMA Board of Trustees and co-chair of the Massachusetts General Hospital LGBTQ Employee Resource Group, will discuss LGBTQ youth mental health care, conversion therapy/sexual orientation change efforts, and advocacy work for the upcoming generations of psychiatrists.

The Intersection of Race, (Trans)Gender, Sexuality, and Mental Health: Creating a LGBTQ+ Patient Safe Space Through an Experiential Learning Perspective

Chair: Ronald R. Holt, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Have a much better understanding of LGBTQ+ terminology; 2) Recognize and understand issues LGBTQ POC face, including coming out, premature disclosure, internalized trans and homophobia; 3) Learn aspects of confidentiality that psychiatrists should consider when working with gender and sexually diverse people; 4) Know the mental and physical health disparities found in LGBTQ+ youth and young adults; and 5) Know the difference between sexuality and gender identify and at what age each can present in youth

SUMMARY:

Research has shown that LGB trans people of color are at higher risk for mental and physical health

disparities due to many things, including discrimination, victimization, bullying, and not feeling safe disclosing their sexuality or gender to health care providers for fear of rejection. Tailored towards psychiatrists, mental health professionals and other related health fields, this highly interactive experiential learning workshop will help participants create a safe clinical environment for LGBTQ+ young adults. Vignettes will be used to discuss issues such as suicidality, mental health confidentiality, LGBTQ+ terminology, the coming out process, and mental and physical health disparities found in LGBTQ+ youth and adults.

The National Neuroscience Curriculum Initiative (NNCI): Preparing for the Future of Psychiatry

Chair: Michael John Travis, M.B.B.S.

Presenters: Melissa Arbuckle, M.D., Ph.D., David A. Ross, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the value of incorporating a neuroscience framework into the every day clinical practice of psychiatry; 2) Feel confident that, even without a neuroscience background, they can integrate cutting edge neuroscience knowledge in routine clinical settings; and 3) Access resources and examples of how they might use new and innovative methods to educate learners and patients about clinically relevant neuroscience

SUMMARY:

Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. An exponential growth in neuroscience research over the past two decades has transformed the scientific literature in psychiatry. Revolutionary new tools have allowed us to study the brain at a level previously unimaginable. Yet most psychiatrists have relatively minimal knowledge of neuroscience. While biological models of mental illness once emphasized “chemical imbalances,” modern perspectives increasingly incorporate a more nuanced understanding of genetics and epigenetics, neurotransmitters and

neuroplasticity, and the functional dynamics of neural circuits. Despite this progress, a neuroscience perspective remains largely absent from the clinical practice of psychiatry. One major reason for this practice gap is the recentness of the change. As seen in Figure 1, direct connections between neuroscience and psychiatry were virtually absent in the medical literature before the 1990s. Thus, most practicing psychiatrists were trained in an era that predated sophisticated biological explanations for mental illness. Unfortunately, few resources exist for those interested in learning clinical neuroscience. Most published articles written by neuroscience experts are at a level of depth and complexity far greater than what is accessible to the audience; equally challenging, these articles are often devoid of clinical context. The few resources that exist for formal continuing education (through either in-person or online training) struggle both with content and process: the majority are narrowly focused on psychopharmacology (a topic relatively disconnected from the most cutting-edge findings in the field). Additionally, to date, neuroscience has generally not been taught in a way that is engaging, accessible and relevant to patient care. Much of neuroscience education has remained lecture-based without employing active, adult learning principles. In order to address this gap, in 2014, we established the National Neuroscience Curriculum Initiative (NNCI), an NIH funded program intended to create, pilot, and disseminate novel interactive approaches for teaching neuroscience. These approaches are intended to bring concepts to life through multimodal learning. These exercises complement traditional teaching approaches and reinforce key learning objectives. For programs without a robust neuroscience curriculum, or those seeking to complement an existing neuroscience course, the NNCI provides participants with easy to use resources that can be implemented locally to enrich the teaching and learning experience. We will outline these approaches and encourage participants to explore them for use in their own teaching.

The Profound and Long-Term Impact of Arkham Asylum on Psychiatry

Chair: Sharon Packer, M.D.

Presenters: Ryan C. Hall, M.D., Fernando Espi Forcen, M.D., Ph.D., Susan Joy Hatters-Friedman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Attendees will be able to discuss the cultural impact of the Graphic Novel Arkham Asylum both on a broad level as well as for psychiatry.; 2) Attendees will be able to identify the artistic significances of images from the graphic novel and appreciate why some images have become iconic in pop culture.; 3) Attendees will be able to identify comic book tropes related to psychiatry and understand where they come from and speculate about the long-term implications of those tropes.; and 4) Attendees will be able to appreciate how the field of psychiatry's history with comic books parallels more contemporary forms of entertainment such as video games.

SUMMARY:

Morrison and McKean's best-selling Graphic Novel Batman Arkham Asylum: A Serious House on Serious Earth (1989) has had a profound impact on the Batman mythology in particular and on popular culture in general. It also perpetuates profoundly negative stereotypes of psychiatrists in the Batman universe, which began in response to Batman-bashing by psychiatrist Fredrick Wertham, M.D. in the 1950s. The graphic novel Arkham Asylum came out the same year as Tim Burton's blockbuster Batman movie. That coincidence alone increased awareness of Arkham and expanded its audience beyond the usual fanboys and fangirls who follow comics culture. Although Arkham Asylum as an institution had surfaced in the Batman universe prior, via a one-sentence mention in a 1974 comic book, the asylum's backstory and its existence as its own "character" was cemented by this work. The graphic novel inspired the video game Arkham Asylum, which became the best-selling video game of all times. The game spawned several sequels and evolved into an ever-expanding Arkham franchise. This panel, whose presenters are all chapter authors in an academic book which explores Arkham Asylum's relationship with psychiatry, will explore various themes, including the representation of psychiatry in pop culture; how art styles influence public perceptions of psychiatry and mental illness;

debates about “transinstitutionalization”; the criminalization of mental illness; the use of psychiatric defenses in court; the relationship (or lack of) between violence and videogames; pop culture’s alleged contribution to the stigmatization of mental illness. Chair Dr. Sharon Packer, who is also the editor of the essay collection on Arkham Asylum and author of *Cinema’s Sinister Psychiatrists* (2012) and *Superheroes and Superegos: Analyzing the Minds behind the Masks* (2009), will address larger issues of cinematic psychiatric tropes. Dr. Espi who has a background in medicine as well as art history will exam the significance of the visual imagery. Forensic Psychiatrist Dr. Friedman will discuss the Psychiatrist character of Dr. Amadeus Arkham and his actions of matricide(spoiler) to show how such characterizations perpetuate the stigmatizing and stereotypes of psychiatric conditions in forensic settings. Dr. Hall will examine the Graphic Novel’s role inspiring the blockbuster Arkham video game series and the striking parallels between speculation about comic books’ and video games’ effects on children’s development. Audience participation is encouraged through Q&A opportunities with the presenters and comments on the art and themes in the graphic novel and video game screen shots.

The Role of Psychiatric Consultation in Patients Seeking Physician Assisted Suicide: Legal, Ethical, Practical, and Psychodynamic Perspectives

Chair: Adrienne D. Mishkin, M.D., M.P.H.

Presenters: Lauren Flicker, Paul S. Appelbaum, M.D., Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current laws and policies surrounding psychiatric assessment in PAS; 2) Recognize the ethical issues regarding capacity assessment before PAS; 3) Appreciate the nuanced possible psychodynamic meanings of a request for PAS for the patient and the physician, and review possible therapeutic responses; 4) Identify evidence for and against having psychiatric evaluation before PAS; and 5) Demonstrate an ability to integrate these perspectives and apply these concepts to patient cases

SUMMARY:

Physician-assisted suicide is legal in Oregon, Washington, Vermont, California, Colorado, Montana & the District of Columbia. The increasing acceptance of allowing patients to take more control over their deaths is an achievement for patient autonomy, but also underscores the importance of thoughtful clinical care, attention to decision making, and legal regulations to protect patients. The current laws regarding PAS specify that the patient must make an autonomous and fully informed decision. Depression sufficient to alter the patient’s judgment is considered an exclusion criterion for PAS, but capacity assessments are not required. The assessment of depression is not standardized, and is often completed by health professionals outside the field of psychiatry. In this workshop, we will explore what the proper role of psychiatry should be regarding patients requesting PAS. We will consider this issue from several perspectives. We will address the legal and policy-related aspects, including understanding the current laws, how those laws are followed, degree of consistency across states allowing PAS, and legal trends in this area. We will discuss in depth how capacity assessments should be tailored for patients requesting PAS, what the ideal process would include, and possible ethical ramifications. We will then consider the psychodynamic meaning of a request for PAS, and will discuss useful therapeutic work for these patients. Finally, we will review the practical limitations and potential benefits of standardizing psychiatric evaluation in the setting of PAS.

The Therapeutic Relationship in Cognitive Behavior Therapy

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Prevent problems in the therapeutic relationship, including potential counter-transferential issues.; 2) Conceptualize alliance problems according to the cognitive model.; 3) Use the conceptualization to resolve therapeutic ruptures.; and 4) Use the therapeutic alliance to help patients improve relationships outside of therapy.

SUMMARY:

Some patients (and therapists) bring distorted beliefs about themselves, their worlds, and other people to the therapy session. As a result of their genetic inheritance, their formative experiences, and the appraisal of their experiences, they develop certain "rules for living" and associated behavioral strategies, which may be adaptive in certain situations but are maladaptive in other contexts. Their dysfunctional beliefs may become activated in the context of psychotherapy and they may employ certain coping strategies which interfere with treatment. Conceptualizing relevant beliefs and strategies is fundamental to planning interventions that can not only strengthen the alliance but that also can be generalized to improve relationships outside of therapy. In addition, specific strategies, such as goal consensus, collaboration, and positive regard, have been demonstrated to be important in building the alliance (Norcross & Wampold, 2011).

The Wrinkling Face of the Opioid Epidemic: Challenges to Medication Assisted Treatment for Opioid Use Disorders in Older Adults

Chair: Pallavi Joshi, D.O., M.A.

Presenters: Robert Rymowicz, D.O., Stephanie Horton Hrisko, M.D., Ketan A. Hirapara, M.B.B.S.

Discussant: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To describe the physical, psychiatric, and substance use comorbidities of older adults in MAT for OUD; 2) To describe the demographic characteristics of the aging population enrolled in MAT; 3) To describe the pharmacological considerations of treating older adults with MAT; 4) To elaborate on the challenges of treating OUD in older adults; and 5) To highlight the need for further research and interventions

SUMMARY:

The prevalence of substance use disorders (SUD) in older adults is rising in the US, and expected to impact over 5.7 million people by 2020 (1). This trend is driven in large part by an aging Baby Boomer generation in which substance use patterns remain high with advancing age (2). Misuse of prescription drugs, particularly benzodiazepines and opioids, is

especially concerning in this population because of the increased risk of fatal and non-fatal overdose. Older adults using opioids are also at higher risk for falls, cognitive and psychomotor impairments, and drug interactions (3). Over the past decade, a dramatic increase in older adults seeking treatment for opiate use disorder (OUD) has unfolded in the United States (4). Yet in the midst of the current US opioid crisis, where treatment efforts are primarily focused on young adults, the use patterns and recovery needs of older adults are often overlooked in routine clinical practice. This discrepancy is reflected in the increase in opioid-related hospital visits among older adults. Between 2005 and 2014, opioid-related inpatient stays increased 85%, and emergency department visits increased 112.1% among adults aged 65 years and older (5). Given these alarming trends, without a robust expansion of addiction treatment capacity for older Americans, we face a devastating compounding of an existing public health crisis. Medication Assisted Treatment (MAT) is an identified strategy for effective addiction treatment. MAT refers to the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders (6). MAT for OUD, which includes methadone, buprenorphine, and naltrexone, has an increasingly diverse array of formulations (i.e. tabs, films, liquid, etc) and delivery methods (i.e. oral, SL, IM, implants). However, treating OUD in older adults is particularly challenging due to physical limitations, medical comorbidities, and polypharmacy, which have implications on monitoring and managing OUD. In this presentation, we will describe the changing demographic characteristics and the physical, psychiatric, and substance use comorbidities of older adults in MAT. We will describe the complex pharmacokinetic dilemmas of methadone, such as its interaction with drugs that impact the P450-3A4 system and its potential for QTc prolongation. We will also provide an overview of the clinical and practical barriers to engaging older adults in MAT, such as prescription insurance coverage and financial limitations. The broad challenges of stigma, low perceived need, and limited access to knowledge of MAT are additional barriers that especially impact the older population, and will be discussed in the workshop.

This Can't Be as Good as It Gets: The Importance of Disruptive Innovation in Reproductive Psychiatry

Presenter: Samantha E. Meltzer-Brody, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the urgent unmet needs in perinatal mental illness; 2) Describe how disruptive innovation is vital to move the field forward and give examples of innovative care models; 3) Describe how technology can improve our ability to conduct population based research and increase our understanding of biomarker contributions to perinatal mental illness; 4) Discuss how an understanding of underlying pathogenesis can inform the development of novel treatment options; and 5) Review the importance of culturally sensitive approaches to diverse patient populations across the globe

SUMMARY:

The concept of disruptive innovative, an approach focused on turning expensive, difficult inaccessible products and services into simpler and more affordable ones, offers the promise of improving our ability to diagnose and treat mental illness across a broad range of settings. Maternal mental health is an excellent model for applying disruptive innovative to psychiatry. The World Health Organization has declared that maternal mental health problems constitute a major public health challenge. One of the most common conditions worldwide is perinatal depression (PND), defined as the onset of depression that occurs during pregnancy (antenatal) or within the postpartum period. The prevalence is estimated at 12% to 20% of pregnant and postpartum women. PND is a significant cause of morbidity and maternal suicide is one of the greatest causes of maternal mortality. PND is also associated with less sensitive parenting resulting in serious adverse sequelae for the child including documented increased rates of neglect, child abuse, and accidental injury. Importantly, severe maternal mental illness rarely but devastatingly can result in infanticide. Yet, in many healthcare settings both in the US and across the world, access to appropriate mental health services have not been fully realized on a population basis. Health systems are often over-stretched and

under-resourced for the provision of mental health care. While there exist accurate assessment tools available to diagnose PND, many obstetrical care services lack an effective and efficient screening process and mental health treatment is often limited. Referral options for affordable mental health care are often scarce. Subsequently, during the vulnerable perinatal period, widely accessible, acceptable, and effective mental health treatment is far too often unattainable for many women, resulting in an urgent unmet need for better options. Additionally, current research demonstrates that susceptibility to PND is a function of epigenetic, genetic, and psychosocial interactions. Increasing our understanding of the underlying pathophysiology is vital for improving our ability to identify those women at risk to inform early detection and treatment of PND. The long-term goal is optimizing outcomes for women and their families affected by PND. This presentation will discuss current models for implementing disruptive innovative approaches to reduce barriers to screening and treatment with the aspirational goal of widely delivering effective treatments (psychological, pharmacologic and other) across a broad range of diverse perinatal patient populations worldwide. It will also describe the importance of conducting translational science to increase our understanding of underlying pathophysiology to optimize treatment for pregnant and postpartum women thereby decreasing adverse outcomes and improving mental health across two generations.

Threatening the President: When Hate Trumps Love

Chair: Charles Leon Scott, M.D.

Presenters: Andrea Lynne Bunker, M.D., Mary Gable, M.D., Scott Eric Kirkorsky, M.D., Lauren Hoffman Marasa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The audience participant will be able to distinguish typologies of presidential assassins.; 2) The audience participant will apply US Supreme Court holdings in evaluating presidential threats.; 3) The audience participant will learn Secret Service approaches to evaluating presidential threats.; 4) The audience participant will apply legal and ethical principles when determining when to

report a presidential threat.; and 5) The audience participant will recognize issues related to medical malpractice in treating potential presidential assassins.

SUMMARY:

Threatening a U.S. President is a serious crime. Four U.S. Presidents have been killed and more than 20 attempts to kill sitting and former presidents and presidents-elect are known. In his first 12 days of office, over 12,000 tweets threatened the life of President Donald Trump. This panel provides practical and current guidance to forensic psychiatrists on assessing and managing threats against a U.S. President, President-Elect, or former President. Dr. Bunker will review three published typologies for evaluating presidential assassins or attempters. Dr. Gable will highlight components of Federal Statute 18 U.S. Code § 871 that outlines the required mens rea to prosecute presidential threats. The U. S. Supreme Court's instructions on evaluating "true threats" as articulated in *Watts v. United States* (1969) will be discussed. Dr. Kikorsky will outline the forensic evaluation of presidential threat-makers including a focus on written vs. verbal threats and the role of the Secret Service in the threat assessment process. Dr. Marasa will review the ethical and legal issues related to decisions to report vs. not report such threats. Dr. Scott will review findings from the malpractice action against John Hinkley's treating psychiatrist for failure to report will be highlighted.

To Treat or Not to Treat: ADHD in College Populations—Diagnosing and Dosing in an Era of Diversion

Chair: Gordon Darrow Strauss, M.D.

Presenters: Aaron Winkler, M.D., Diane Beth Gottlieb, M.D., Leigh Anne White, M.D., Bettina U. Bohle-Frankel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore and discuss the use of stimulant medications in college and university students; 2) Identify populations that require special attention when treating ADHD; and 3) Establish best-practice guidance when using stimulants in college students

SUMMARY:

In the United States, 7.2% of undergraduate college students come to college already receiving prescriptions for stimulant medications and many seek care from college mental health providers for continuation of prescribed medication. The population seeking ADHD treatment for the first time is not homogeneous and requires individualized attention, precluding the use of "one size fits all" prescribing guidelines. Groups posing special challenges include student athletes, professional students (including medical, dental and law students) and minority student populations. There has also been a rise in the misuse of stimulant medications by college populations, currently reported to be around 17%, with a lifetime prevalence between 8 and 43%. At the same time, risk-taking and illegal behaviors are reduced significantly in the 30 days after a stimulant prescription is filled and the benefit of appropriately dosed stimulant medication for people with ADHD is well-documented. On campus stimulant misuse is often associated with the drive to achieve the goals valued by parents, teachers and professional school admissions officers. Students feel unable to sustain attention to dry, dense material and to simultaneously complete multiple assignments while keeping up with activities of daily living. Supplying students with the tools to succeed in academia, both undergraduate and graduate, may involve not only prescribing medications, but also helping them individuate from parents, assimilate different cultures, master stress and time management skills, and cope with comorbid diagnoses. Providers treating college students, both within the institutions and in the community, find themselves with the burden of meeting the needs of multiple stakeholders while correctly identifying and treating those in need. In this session we will review current data, present a balanced perspective and provide a framework for approaching these complex cases. We will also offer insight into specific student populations and the ethical dilemmas that they present.

Trauma-Informed Care: How to Develop a Curriculum?

*Chairs: Bibiana Mary Susaimanickam, M.D.,
Geetanjali Sahu, M.B.B.S.
Presenter: Iram F. Kazimi, M.D.
Discussant: Yasas Chandra Tanguturi, M.D., M.P.H.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the importance of having a trauma curriculum in a general residency program; 2) Identify 3 core components of a robust trauma curriculum; 3) List strengths and deficits with regards to trauma curriculum within their residency program; 4) Describe 3 resources which can be used to strengthen trauma training; and 5) Develop a personal action plan to implement in their worksite

SUMMARY:

According to National Child Abuse and Neglect Data System during Federal Fiscal Year 2015, an estimated 683,000 children in the 50 States, the District of Columbia, and Puerto Rico were determined to be victims of abuse or neglect. Nationwide community studies estimate between 25% and 61% of children and adolescents have a history of at least one exposure to a potentially traumatic event and 38.5% of American adults claim to have experienced at least one traumatic event before the age of 13. It has strong implications on mental health. It is essential that psychiatrists are apt at recognizing and treating trauma victims. However, growing number of studies suggest that majority of abuse cases are not identified by mental health services. To address this gap in education and competence we started a trauma curriculum with the aim that psychiatry residents must learn to sensitively and validly identify and appropriately respond to patient histories of trauma in their various forms., Depending on their background, providers may or may not have knowledge of identifying and treating trauma patients. Lack of knowledge can make treating a trauma patient a very emotionally draining or distressing experience for a provider. Our curriculum provides a comprehensive education about epidemiology, neurobiology, symptomatology and treatment of trauma, along with education about self-care. This interactive workshop will focus on importance of having a trauma curriculum in training and the resources one can use to build a robust trauma informed program. Attendees will not

only identify the core components of a trauma curriculum but will also brainstorm ideas to improve/build a trauma curriculum in their respective programs. A list of resources will also be discussed and provided which they can utilize according to their needs. This workshop can be helpful to training directors and residents to help address Patient Care, Medical Knowledge and Professionalism components of ACGME milestones for general psychiatry residency in their program.

Treating Anxiety and Traumatic Stress-Related Disorders With MDMA-Assisted Psychotherapy: Evidence and Insights

*Chair: Michael C. Mithoefer, M.D.
Presenters: Candice Monson, Ph.D., Charles Grob*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Will be able to describe the rationale for studying MDMA in conjunction with psychotherapy; 2) Will be able to list the risks and possible benefits of MDMA administration; 3) Will be able to describe and consider shared and different issues facing MDMA-assisted psychotherapy in autistic adults with social anxiety and individuals with severe PTSD; and 4) Will be able to recount the results of Phase 2 clinical trials of MDMA-assisted psychotherapy

SUMMARY:

There is interest in developing an array of new treatments for posttraumatic stress disorder (PTSD), and for social anxiety disorder in autistic adults. Existing PTSD treatments are not effective for a substantial percentage of patients, and treatment discontinuation due to medication side effects or increased distress during trauma-focused therapies further hampers treatment. Standard therapeutic approaches to reduce social anxiety in autistic adults have limited effectiveness. Evidence from randomized, blinded [phase 2] clinical trials supports methylenedioxymethamphetamine (MDMA) assisted psychotherapy for posttraumatic stress disorder and social anxiety. This treatment combines MDMA administration under direct supervision combined with manualized psychotherapy. Significant improvement has been seen in people with chronic PTSD and in autistic adults with social anxiety. We

will discuss the history and future of this treatment, including background, hypotheses concerning mechanisms of action, and findings from a series of completed Phase 2 studies that enrolled victims of sexual abuse or violent crime, military veterans or first responders with service-related PTSD, dyads containing one individual with PTSD, and individuals with social anxiety. The design of ongoing Phase 3 studies that have received “Breakthrough Therapy” designation from FDA will also be presented. The manualized method of MDMA-assisted psychotherapy will be described, as will the structure of the ongoing training program for MDMA research therapists. Dr. Grob will present results of a study in which autistic adults with marked to very severe social anxiety were randomized to receive moderate dose MDMA during 8-hour long psychotherapy sessions in a controlled clinical setting. Double-blinded experimental sessions occurred about 1 month apart with 3 non-drug psychotherapy sessions afterward. The primary outcome was change in Leibowitz Social Anxiety (LSAS) total scores from Baseline to 1 month after the second experimental session. Improvement in LSAS scores from Baseline to the Primary Endpoint was significantly greater for the MDMA group compared to the placebo group, and placebo-subtracted Cohen’s d effect size was very large. Dr. Monson will share the rationale for incorporating MDMA with Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT). This will include a discussion of the theory underlying this trauma-focused, interpersonally-oriented psychotherapy and the mechanisms of MDMA in psychotherapy. Results of a recent uncontrolled study of MDMA-facilitated CBCT will be presented. Overall, the session will examine several models and theoretical frameworks for MDMA-assisted psychotherapy and will present key elements of creating a conducive environment for successful MDMA-assisted psychotherapy.

Typical or Troubled?®: Program Update and Further Development Discussion

*Chairs: Christopher Seeley, Daniel H. Gillison Jr.
Presenter: Louis James Kraus, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the current state of

school mental health; 2) Discuss the three parts of the Educational Staff members role; 3) Discuss the curriculum and delivery model changes; 4) Discuss the Instructor Certification Process for APA Members; and 5) Discuss program future developments and how members can get engaged

SUMMARY:

Adolescent mental health is a critical area of focus for researchers, teachers, parents, and lawmakers. Adolescents spend a majority of their day with teachers and are readily accessible through school-based programs, which makes the classroom a convenient frontline setting for intervention. One of the largest reviews of school-based promotion and prevention studies confirmed that educational programs can reduce mental health problems in a useful and reasonable way. Teachers work closely with teenagers and are ongoing observers of their usual behaviors, social interactions, and emotions. Therefore, teachers can promote positive mental health, resilience, and coping skills. The American Psychiatric Association Foundation has had their school-based education program Typical or Troubled?® (ToT) in the field since 2006. ToT is a Professional Development program for middle and high school teachers and relevant school personnel. The training covers 3 main areas: 1) train teachers and relevant school personnel to notice the warning signs of emerging mental health conditions; 2) increase the capacity of teachers and relevant school personnel to effectively talk with a student showing signs of an emerging mental health condition; and 3) increase the knowledge of teachers and school personnel to act by connecting students and their families with appropriate mental health services and supports. There has been a large effort made by the APA Foundation, APA Members, School Mental Health Professionals, and Educators to redevelop the curriculum and delivery model. During this general session individuals will learn about the History of the Typical or Troubled?® Program, learn about the new E-Learning Module, learn about the updated Classroom Module, and learn about the Instructor Certification process. This general session will end with three breakout topic areas that will engage the individuals attending to help in the creation of a Parent Component, a Peer-to-Peer Component, and further Resource Development.

Updates in Child and Adolescent Psychiatry: Mood Disorders, ADHD, and Psychosomatic Considerations

Chair: Bruce D. Miller

Presenters: Bruce D. Miller, Beatrice Wood, Graham J. Emslie, M.D., James G. Waxmonsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Comprehend the interplay of depression with other chronic conditions in children and adolescents, including asthma, aids, and ADHD; 2) Appreciate that parental depression impacts child and adolescent depression and chronic illnesses, and recognize pathways by which this occurs; 3) Understand potential psychobiological mechanisms by which depression impacts chronic conditions in children and adolescents; and 4) Apply the knowledge gained from this presentation to the assessment and treatment of children and adolescents with comorbid depression and chronic medical conditions

SUMMARY:

Depression affects approximately 7% of the general child/adolescent population, and the prevalence is considerably higher in youth with chronic medical illness. Nearly one quarter of youth with moderate to severe asthma are depressed, and this comorbidity is associated with increased asthma morbidity and mortality. Dr. Miller will present a psychobiological model showing how depression affects neural pathways implicated in asthma, and mechanisms by which depression can lead to increased airway constriction and inflammation under conditions of emotional distress. He will present data supporting these neurally mediated connections, discuss their clinical relevance, and consider treatments to effectively intervene when these conditions co-exist. Caregiver depression plays a key role in the cascade of socio-familial-psychological- biological effects on childhood asthma. Dr. Wood will review findings that show that childhood asthma is affected indirectly by socio-economic status and family stress, mediated by caregiver depression. Caregiver depression impacts disease management, and/or stress and depression in the child, which, in turn, affect asthma through

alterations in immune modulation and autonomic regulation. She will focus on findings from a laboratory-based family emotional stress paradigm in order to present evidence for pathways of effect by which caregiver depression impacts child asthma. Depression in adolescents is a chronic illness, and is characterized by “3 R’s”: Recurrence, Relapse, and Recovery. While studies have focused on acute treatments, pharmacological and psychotherapeutic, little has been done on getting depressed adolescents well and keeping them well. Dr. Emslie will focus on long-term outcomes of depression in adolescents, predictors of relapse, prevention of relapse, and promoting recovery and resilience. In addition, he will discuss an ongoing study of combination medication management and Health & Wellness CBT in adolescents and young adults with depression and HIV. Dr. Waxmonsky will present on the intersection of mood and externalizing symptoms in children and adolescents, with a focus on irritability in school aged youth. He will discuss the current standards for assessing irritability in youth and its associations with specific psychiatric disorders as well as what is known about the etiology of irritability and excessive temper outbursts. He will also review the treatment literature for the management of irritability and aggression in children and adolescents, including both pharmacological and psychosocial interventions. In addition, he will review longitudinal course of irritability and its associations with adult psychopathology.

Using Biological Measures to Reclassify Psychosis

Presenter: Godfrey David Pearlson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice.; 2) Apply quality improvement strategies to improve clinical care.; 3) Provide culturally competent care for diverse populations.; 4) Describe the utility of psychotherapeutic and pharmacological treatment options.; and 5) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:

Traditional diagnostic schemes in psychiatry (e.g. the DSM and ICD) define psychiatric conditions such as schizophrenia or bipolar disorder based on cross-sectional symptoms and longitudinal course, an approach that dates from the 1890s and has not been significantly updated conceptually. Unfortunately, conditions encompassing psychosis (e.g. schizophrenia, psychotic bipolar & schizo-affective disorders), overlap on multiple levels. Overlap occurs at the level of symptoms, co-occurrence within families, risk genes and response to treatment. The multi-site B-SNIP consortium (Bipolar-Schizophrenia Network on Intermediate Phenotypes) asked two big questions. 1. Could biological measures such as those derived from structural or functional MRI, cognitive tests, EEGs, genotyping and eye movement physiology provide a firmer basis for classifying these illnesses from each other, by deriving a distinct biological "fingerprint" that corresponded to each DSM condition? 2. What would happen if we used these biologic measures irrespective of classic clinical DSM psychiatric diagnosis, to try and create homogeneous disease entities from the bottom up? As well as addressing these questions, I will highlight how mentored individuals, ranging from research assistants, pre- and postdoctoral students to junior faculty contributed at each stage to the B-SNIP project.

Using Inflammation to Personalize Antidepressant Therapy

Chair: Daniel Lindqvist, M.D., Ph.D.

Presenters: Madhukar H. Trivedi, M.D., Andrew H. Miller, M.D., Mark Hyman Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how inflammation is involved in the pathophysiology of depression; 2) Describe how inflammatory molecules influence neurotransmitter systems, including dopaminergic and glutamatergic pathways, to generate depressive symptoms; 3) Understand that inflammation may be more pronounced in certain subtypes of depression, given the heterogeneity of the disorder; 4) Review potential clinical implications of inflammatory biomarkers in selecting antidepressant treatments; and 5) Design clinical trials to advance personalized psychiatry, e.g. by enriching patient populations

based on inflammatory biomarkers or related symptom profiles

SUMMARY:

Antidepressants have relatively low rates of response and remission, and there are no clinically established predictors for treatment response. The heterogeneity of MDD has hampered the development of targeted pharmacological interventions; i.e. potential treatments that might have beneficial effects for a given subtype of MDD. The use of biomarkers for enrichment of patient populations might delineate more homogenous subsamples and thereby identify more specific treatment options. "Personalized psychiatry", taking into account unique features of a given patient's pathology in formulating treatment plans, and improved patient stratification are strategies to address such issues of sample heterogeneity. Inflammatory markers have been suggested as candidate biomarkers for stratifying subjects in antidepressant trials testing anti-inflammatory and other drugs (1). Increased blood levels of inflammatory markers have repeatedly been reported in individuals with MDD compared to controls (2-4), although there is considerable overlap between groups. As further evidence for a link between inflammation and depression, individuals exposed to inflammatory stimuli develop significant depressive symptoms (5). Inflammatory cytokines may generate depressive symptoms via their influence on neurotransmitter systems including dopamine and glutamate (1). Some depressive symptoms, such as anhedonia, fatigue, and appetite/sleep disturbances, have been more closely linked to inflammation than others (6), suggesting there might be an inflammatory biotype of depression that could be distinguished based on inflammatory biomarkers and symptom profiles. Emerging data suggest that inflammatory blood based markers predict treatment outcome with various antidepressant compounds (7-9), highlighting the potential clinical usefulness of this concept of "inflammatory depression". Specifically, increased inflammation has been associated with worse response to SSRIs, and superior response with certain dopaminergic antidepressants as well as novel anti-inflammatory compounds. In this session experts in the field will i) review available data on

the ability of inflammatory biomarkers to predict efficacy of currently used antidepressants and novel anti-inflammatory compounds, ii) describe ongoing and completed clinical trials using inflammatory biomarkers for enrichment of patient populations, and iii) discuss potential biological mechanisms underlying the link between inflammation and depression and the antidepressant effects of anti-inflammatory compounds. There is a clinical need to both accurately match patients with current treatments as well as identify new antidepressants to target inflammatory biotype. The main purpose of this session is to outline how this can be achieved. We aim to inform future clinical trial designs and thereby pave the way for personalized medicine in psychiatry.

Using Newer Technologies to Enhance Psychiatric Care and Patient Engagement

Chair: Alisa B. Busch, M.D.

Presenters: Ipsit Vihang Vahia, M.D., Justin Taylor Baker, M.D., Ph.D., Nicole M. Benson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Understand how passive sensing coupled with artificial intelligence can augment clinical monitoring and enable earlier interventions in patients with dementia.; 2) 2.

Understand the security and privacy issues with emerging technologies that employ passive sensing for monitoring patient activity.; 3) 3.

Identify at least 2 ways that mobile applications (apps) can support patients and providers in a peer-led community of patients with chronic, severe and persistent mental illness.; 4) 4.

Understand HIPAA requirements for messaging between patients and providers; and 5) 5.

Recognize patient characteristics and provider/office workflows that are important to consider when selecting a messaging technology for patient to provider secure communication.

SUMMARY:

Patients with psychiatric illnesses often struggle with neuropsychiatric symptoms—such as difficulties with executive functioning, cognition, anergy, psychosis, and insight—that can adversely impact their ability to receive care, engage in care, and adequately

communicate the severity of their symptoms to caregivers and psychiatric providers. New technologies, some emerging and some already deployed in health care but not tested in psychiatric settings, offer new opportunities to engage patients in care and improve clinicians' ability monitor progress and intervene earlier if patients are experiencing worsening symptom or functioning difficulties. This session will describe efforts to deploy newer technologies in psychiatric care to improve patient engagement, empowerment in care, and augment clinical monitoring and earlier intervention. We focus on patients with early psychosis, and patients with dementia. These illnesses, despite being at opposite ends of the lifespan, share many of the same management challenges for patients, families and providers: individuals in need of illness surveillance in the face of potential functional declines that might be opaque to that individual, a need to balance that individual's sense of personal autonomy and agency, and the importance of engaging an individual in treatment despite the neurocognitive symptoms that make engagement challenging.

Utilization of Medications for Opioid Use Disorder Treatment in Justice Populations

Chair: Tisha Wiley

Presenters: Josiah Rich, Joshua Lee, M.D., Yngvild Olsen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Share insights into special considerations in engaging and retaining justice-involved patients receiving MOUD; 2) Discuss implications of patient choice in utilization of MOUD with justice-involved patients; and 3) Discuss effectiveness data for MOUD with justice-involved populations

SUMMARY:

Medications to treat opioid use disorder (MOUD) are one of the most effective tools available in addressing the opioid epidemic. Many individuals with opioid use disorder are justice involved. Increasing severity of opioid misuse is linked to increased likelihood of justice involvement. Unfortunately, justice-involved individuals are less

likely than their non-justice involved peers to access pharmacotherapy for OUD. Involvement in the justice system creates barriers to treatment, including forced treatment cessation during incarceration, challenges in engaging or re-engaging in treatment when returning to the community after release, and lack of support for MOUD while under community supervision. Many of these practices are slowly changing, but numerous barriers remain and create unique needs for justice-involved patients receiving community-based treatment. In this session, investigators funded by the National Institute on Drug Abuse will share insights into special considerations in engaging and retaining justice-involved patients receiving MOUD. Insights from studies utilizing extended-release naltrexone (XR-NTX), buprenorphine, and methadone will be discussed. Presentations will also highlight the role of patient choice, reflections on the role of supportive behavioral interventions and implications of the emergence of availability of illicit fentanyl and its congeners.

Wellness Isn't Working: NYC Residents' Perspective on the Crisis That Is Killing Us and What We Can Do About It

Chair: Anne Clark-Raymond, M.D.

Presenter: Mena Mirhom, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current healthcare crisis of physician suicide, from the perspective of trainees; 2) Demonstrate an appreciation for the complexity of the problem that residents are facing and the need for a grassroots solution; and 3) Provide concrete examples of initiatives that are currently in place in training programs in New York City, in order to perhaps expand on them in their own training program

SUMMARY:

How did the tragic death of a resident physician go from a shocking headline to an expected part of Tuesday's headline? Somewhere along the way, our statistics and inundation with talk of physician "wellness" have numbed us to the fact that there is a major crisis that is taking place around us. The fact that more than 1 million Americans a year lose their

doctors to suicide does not seem to spur us into drastic action. Trainee suicide is an alarming subset of this phenomenon. As the co-chairs of the Residents' Committee of the New York County District branch of the APA, we have decided to take action. We've made this issue our goal and focus. When we began to have honest dialogue about this among New York City residents, we found that the real story is often not being told from the resident's perspective. The approach of rolling out initiatives from the ivory tower of higher administration continues, and it is our opinion that these measures, while well-meaning, are ineffective and missing the mark with unfortunately tragic results. In this APA discussion, we hope to accomplish three very simple yet critical goals. First, we hope to highlight this issue from the perspective of a psychiatry resident. It is only by truly understanding the reality of the problem of trainee suicide, can we begin to propose effective solutions. Second, we will highlight the resident-led initiatives that have been taking place throughout New York City. These ideas may not be the answer for every program, but we believe that they represent a paradigm shift in our approach to this crisis. Lastly, we hope to engage the audience on this topic in order to share ideas, experiences and realistic initiatives that go beyond the surface of generalized "wellness activities" to truly target what we believe to be some of the root causes of poor trainee mental health. We will be sharing anonymous but true stories from real residents and asking the audience for their feedback on how they would respond in these situations. We will also discuss how these scenarios demonstrate the presence of larger institutional barriers to addressing our true wellness.

"What Were You Thinking?" A Keystone Question for Emotional Fitness

Presenter: Loma Kaye Flowers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Distinguish between mental health or wellness and emotional fitness.; 2) Discuss the role of emotional intelligence skills and emotional competence (EC) in emotional fitness.; 3) Recognize the cognitive skills that support mental health and emotional fitness in preventing, as well as

tolerating and recovering from mental illness.; 4) Identify some components of a systematic approach to emotional and social competence.; and 5) Observe social and emotional skills in themselves and their environments and name one tool utilizing analytic thinking for enhancing these skills.

SUMMARY:

Thinking for Yourself: A Gateway to Emotional and Social Competence In the last 30 years, social and emotional intelligence skills have been demonstrated to increase successful outcomes for individuals and groups. Yet because of our primary focus in psychiatry on diagnosis and treatment—and minimally on prevention-- we have a ways to go in the early identification of thought patterns and habits that positively support emotional fitness in patients and professionals. Equally important, is the utilization of emotional and social competence concepts, principles and skills in designing our mental health services. This presentation provides a practical, operational definition of social and emotional competence [EC] and discusses a systemized approach to utilizing basic EC skills from that approach. These skills can be applied universally to problems we encounter to facilitate the development of constructive action plans. Two EC protocols are included, both of which require a variety of different types of thinking. First, a Considered Response, which involves analytical thinking, emotional literacy for emotional sorting and processing, good judgment and creative planning before action. Second, journaling Facts & Feelings. Both approaches can be learned, implemented and practiced regularly to increase emotional competence on both the individual and community level. Opportunities and barriers to enhancing EC in the field of psychiatry will also be explored

Why Artificial Intelligence and Computational Neuroscience Should Be Taught to Psychiatry Residents

Chair: Ron M. Winchel, M.D.

Presenter: Alan Kuo-Hin Louie, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the speaker's position

that psychiatric residents should learn about artificial intelligence and computational neuroscience.; 2) Describe two future examples of applications of machine learning and computational methodologies to psychiatry.; and 3) Outline the challenges facing educators in teaching residents about artificial intelligence and computational neuroscience.

SUMMARY:

Artificial Intelligence (AI) is becoming ubiquitous and is embedded in our society in many ways, e.g., email spam filters, self-driving cars. Computational neuroscience is bringing new analytical methods to neuroscientists for the study of complex systems, like the brain and behavior. Both have great promise for applications in psychiatric research and practice. When they will play a major role is not clear, but psychiatric educators need to anticipate what today's learners will need tomorrow. The increasing levels of complexity of the brain that are revealed each day suggest that tomorrow's psychiatrists will indeed need more sophisticated tools, and computational ones may well be among them. Future applications of AI and computational neuroscience to psychiatry will be illustrated with two examples. First, wearable devices will allow psychiatrists to "observe" behavior with much greater granularity than previously available; at the very least, they will provide a window on the complex patterns of the what, when, and where of a person's daily behaviors. Wearables will generate reams of data that will only be interpretable by applying a form of AI, which is machine learning or deep learning. Second, psychiatric diagnosis has been at an impasse, despite attempts to connect the description of gross behaviors found in DSM to some understanding of brain pathophysiology. The task of making multi-scale connections between molecules, neurons, circuits, networks, and behaviors (across the biopsychosocial continuum) has just been too complex to date. The intricate and convoluted design of these connections might only be disentangled by new computational methodologies used to simulate or predict brain activity and behavior. Given this proposition that psychiatric residents should learn about AI and computational neuroscience, educators will face two challenges. First, educators need to know how much to teach of

these fields outside of psychiatry and how to do so in a clinically relevant manner. They have been confronted with similar issues regarding the teaching of molecular neuropharmacology and/or genomics to residents. Second, for residents to comprehend the approach of AI and computational neuroscience, they will have to become familiar with paradigms less common in medicine. These are paradigms, more common in engineering, that differ from the scientific method taught in medical school and which has so dominated medicine. Into the future, brain science will generate gigantic data sets, too complex for the scientific method, which will require an “engineering design process” approach.

Why Is My Career Stuck? Successful Career Planning for Women

Chair: Gail Erlick Robinson, M.D.

Presenter: Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the importance of finding a mentor; 2) realize the types of communications that interfere with women's career success; 3) know how to negotiate more successfully in a new job; and 4) evaluate potential career moves in order to make the most advantageous choices.

SUMMARY:

Women often have difficulties making successful career choices. They need to understand the value of mentorship and how to find and effectively use mentors. In evaluating a job proposal there are many things to consider such as: how does it fit with career, family and geographic needs; does it have advancement potential; is it a long or short term opportunity; what are the pros and cons, the advantages and trade-offs ; and what perks or benefits make it more or less worthwhile. Women are often hesitant to negotiate and may say yes or no to a position too quickly. Once in a position, they need to avoid communication pitfalls and learn how to speak up in a manner such that they will be heard at meetings. Women need to understand the importance of "self-promotion" by letting others know about their successes. This workshop will

provide tools and insights necessary for successful career planning.

Women in Medicine: Challenges, Leadership, and Systemic Issues

Chairs: Amy W. Poon, M.D., Richa Bhatia, M.D.

Presenters: Christina T. Khan, M.D., Ph.D., Ranvinder K. Rai, M.D.

Discussant: Silvia Wybert Olarte, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the underrepresentation of women physicians in leadership roles, the potential reasons, and how to address this gender gap.; 2) Identify the connection between mental health stigma and its impact on women physicians.; 3) State the current rates and prevalence of mental health disorders in women physicians.; 4) Understand how implicit bias contributes to the gender gap and negatively affects women physicians of color, in particular.; and 5) Demonstrate their understanding of how systemic issues affect women physicians and identify strategies for improving them.

SUMMARY:

Despite greatly increasing numbers of women in medicine in the last several decades, women physicians continue to be underrepresented in leadership roles. Higher attrition rates for women as they progress through their careers, implicit gender bias, challenges with work-life balance are some of the factors that may account for this. This scarcity is not due to differing ability than male physicians. Additionally, women leaders are often questioned based on whether their style conforms to gender expectations. We will review challenges for women physicians and the leadership gap. Specific programs aimed at recruiting, retaining and mentoring may help increase representation of women psychiatrist leaders. Mental health stigma is associated with lower rates of seeking help, undertreatment, and social isolation. More than 2/3 of female physicians reported mental health stigma as a barrier to seeking care, citing fear of jeopardizing one's medical license, or being negatively perceived by one's colleagues or patients. Untreated mental health conditions pose a risk factor for suicide

among physicians. The suicide risk in physicians is higher than the general population; however, female physicians have an even greater relative risk of suicide, 2.27 times greater than the general population. The gender gap for women in STEM disciplines begins early and is marked by a “leaky pipeline” where attrition occurs at every stage of women’s scientific careers. Stereotypes and biases, often unconscious, have been shown to limit women’s progress, while strategies such as improving departmental culture and work environment, mentorship and representation can help to address the effects of systemic bias. Women of color face a double bind, where gender and race/ethnicity intersect to increase the likelihood of negative outcomes, including disparities in compensation, rates of NIH funding, and academic advancement and retention. We will review the data demonstrating the impact of bias on women of color in medicine, and discuss strategies and solutions that can make a difference in reversing the glass ceiling. Although encouraging well-being and wellness can be helpful, such concepts can be used negatively against women too. The idea that women need more stress management or resiliency training because of higher rates of depression can result in “victim-blaming,” neglecting the myriad of systemic issues that contribute to stress, burnout, and subsequent mental health problems. Other systemic issues, especially during the high-risk period of training, include: sleep deprivation, social isolation from long work hours, experiencing bullying and humiliation, and financial stress. Strategies for improvement include better working conditions during training, implementing family-friendly policies, reducing the effects of gender-related bias, and supporting women throughout their careers.

Wednesday, May 22, 2019

A Comprehensive Framework for the Office Evaluation of the Neurocognitive Disorders

Chair: Vimal M. Aga, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the 6 steps involved in assessing patients with cognitive complaints in the office efficiently yet

comprehensively; 2) Differentiate between the common NCD types based upon patterns of cognitive deficits; 3) Learn about cognitive impairment in late-stage bipolar disorder and schizophrenia; 4) Assess NCD patients for dangerousness to self and others; and 5) Utilize the 6 assessment steps to create a case formulation which in turn informs further management

SUMMARY:

A thorough assessment of the neurocognitive disorders (NCD) requires in-depth knowledge of not only psychiatry but also several aspects of geriatric medicine, neurology, neuroimaging and even medical ethics. The presenter has developed a practical 6-step approach for the efficient evaluation of patients with cognitive complaints in the office. During the session, each of the 6 steps will be illustrated with the help of a real case. The presenter will start by differentiating between major and mild NCD (as per DSM-5) and subjective cognitive decline or SCD (not in DSM-5), explain why assessment of prospective memory is important in SCD and identify which “worried well” patients need to be scheduled for follow up. A quick overview of the six DSM-5 cognitive domains will then be provided, focusing on an office assessment of cognitive deficits in various areas including verbal fluency, apraxia of speech, surface dyslexia, simultanagnosia and the apraxias. A simple AD8 based form will be introduced for history taking. Attendees will learn how to differentiate delirium from NCD and between the types of NCD, based on patterns of cognitive deficits. Patterns of deficits in the neurodegenerative NCD will be compared and contrasted with cognitive decline seen in late-stage bipolar disorder and schizophrenia. A scheme for assessing Neuropsychiatric Symptoms (NPS) of dementia will then be presented, which will include a discussion of the often overlooked delusional misidentification syndromes in Dementia with Lewy Bodies. The relatively new construct of Mild Behavioral Impairment, which is still in evolution, will be introduced and its special relevance to psychiatric practice will be emphasized. Lab tests for reversible and rapidly progressive etiologies will be enumerated. The role of CSF and neuroimaging biomarkers in diagnosing the neurodegenerative NCD will be elucidated next, and attendees will learn

when to order structural, functional and/or molecular imaging and how to use the Amyloid Tau Index to diagnose Alzheimer's disease (AD). The recent ATN classification of AD and the 2018 NIA-AA Research Framework will be used to explain the significance of biomarker testing in NCD. Indications for using genetic testing in select NCD cases will then be presented. Assessment for 3 types of dangerousness in NCD, including the rational suicide, will complete the evaluation steps. Attendees will then be invited to participate in an exercise whereby the 6 steps will be used to arrive at a succinct case formulation in order to guide further management. The session will conclude with a robust Q&A session and the presenter will recommend further resources for self-directed study, both print and web-based. The entire session will be packed with practical clinical pearls; while all attendees will benefit, the session is best suited for clinicians with some prior knowledge and experience in evaluating and treating patients with NCD.

A Web-Based Decision Aid Tool for Disclosure of Mental Ill Health in the Workplace: A Randomized Controlled Trial

Chair: Nick Glozier

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand how web-based tools can aid decision making; 2) learn how to evaluate correct reading age for patient materials; and 3) appreciate positive impact of disclosure

SUMMARY:

Deciding whether or not to disclose a mental illness in the workplace is often complicated, with different considerations. Under many countries' disability legislations, individuals need to disclose their mental illness in order to receive reasonable adjustments. Decision aid tools are designed to help an individual make a specific and deliberate choice. We developed a web-based decision aid tool (READY) to help inform decisions about disclosure for individuals in current employment. Aims: This study aimed to examine the efficacy of this decision aid tool, compared to the online information currently provided by a leading mental health charity, on disclosing a mental health condition in the

workplace. Method: A double-blinded parallel arm randomised controlled trial was conducted. Participants had open access to the READY web-based decision aid tool or the online disclosure information for two weeks. Assessments occurred at baseline, post-intervention, and 6 weeks post baseline. Results: A total of 107 adult employees were randomised to the READY intervention (n=53) or the active control arm (n=54). The average age was 34.3 years. The sample was predominantly; female (83.2%), not married (61.7%), not Aboriginal or Torres Strait Islander (97.2%), and employed in the social and community services industry (30.8%). Participants in the READY arm showed greater reduction in decisional conflict at post-intervention ($F(1,104) = 16.8, p = <.001$) ($d=0.49, CI=0.1-0.9$), and follow-up ($F(1,104) = 23.6, p = <.001$) ($d=0.61, CI=0.1-0.9$) compared to the control arm. At post-intervention the READY group were at a later stage of decision making ($F(1,104) = 6.9, p=0.010$) which was sustained, and at follow-up the READY group showed reduced decisional dissatisfaction ($F(1,104) = 7.5, p=0.008$), and depression scores ($F(1,104) = 6.5, p=0.013$) compared to the control group. Conclusion: READY provides a confidential, effective tool to enable employees to make an informed decision about which disclosure option is best for them. There was no indication that the tool, or making a decision, led to harm and the mental health of those who disclosed improved. READY is being incorporated into government mental health workplace support programs.

Accelerated Biological Aging in Psychiatric Patients: New Advances and Clinical Implications

Chair: Owen Mark Wolkowitz, M.D.

Presenters: Daniel Lindqvist, M.D., Ph.D., Kristoffer Månsson, Aric Prather, Ph.D., Josine Verhoeven

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the high levels of medical morbidity in psychiatric patients; 2) Understand the concept of biological aging and how this relates to psychiatric disorders; 3) Identify markers that may indicate biological aging; and 4) Discuss possible interventions to lessen this effect

SUMMARY:

Several psychiatric disorders are associated with increased comorbidity of medical conditions more typically associated with aging, including cardiovascular disease, stroke, dementia, diabetes, obesity and all-cause early mortality. While part of this association may be explained by differences in health behaviors, the link between psychiatric disorders and medical morbidity remains significant even after adjusting for such factors. This has led to the hypothesis that psychiatric conditions may induce or result from accelerated or premature biological aging. There are multiple cellular and molecular indicators of biological aging, including telomere length, mitochondrial changes, gene transcripts, DNA methylation status and others. Some of these indicators have been widely researched in psychiatric illnesses while others remain relatively unexplored despite the obvious significance of such findings. Emerging data suggest that some of these biological age indicators may predict or monitor treatment outcome with pharmacological as well as behavioral interventions and that such interventions may affect the course of biological aging. Our session will introduce the concept of biological aging and describe current methods used to estimate biological age, together with the pitfalls. We will provide an up-to-date review of biological aging research in psychiatric illnesses. Importantly, we will discuss potential remediable mediators of biological aging, clinical relevance and treatment possibilities based on these markers as well as future challenges in this field.

According to Stephen Hawking, We Live in the Century of Complexity: Effectively Addressing Complexity in Clinical Care and Teaching

Chairs: Alison Margaret Heru, M.D., Sarah A.

Nguyen, M.D.

Presenters: Gabor Istvan Keitner, M.D., Douglas Rait, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how complexity provides a more effective approach compared with an approach that reduces problems to their smaller parts or their linear “cause and effect” relationship; 2) Understand how to use a system-based approach to evaluating and treating patients with psychiatric

disorders in varied clinical settings.; 3) Understand complex system theories such as evolutionary systems theory, and their application to clinical situations.; and 4) Discuss innovative ways to teach systems-based practice in residency programs and highlight importance of systems thinking.

SUMMARY:

Doctors are trained to troubleshoot and solve problems using reductionist thinking: breaking down ambiguity, resolving paradoxes, and achieving certainty. Complex systems theory support a more nuanced approach. Evolutionary systems theory describes biological systems as adaptive and self-organizing. Self-organization allows the emergence of higher-order systems such as family hierarchies. From inside a family or cultural system, members ‘infer’ or ‘see’ the environment filtered through its beliefs and values. Current psychiatric care, especially in acute care settings, focuses on diagnostic evaluation, including an emphasis on checklists. This reductionist frame misses critical information about the person and their social circumstances, such as the patient’s personality, values, culture, meaning in life and social relationships. Case vignettes illustrate how a systems perspective creates the opportunity to arrive at a more meaningful formulation and treatment plan. Audience examples will be elicited and discussed. To understand the interpersonal contexts in which individual behaviors and problems exist, we need a conceptual shift and conceptual clarity that accounts for complementarity, family of origin influences, and identification of systemic patterns. Video clips from popular films will illustrate these points and engage the audience, providing a foundation for the application of systemic thinking. Systems-based practice is one of the most abstract ACGME core competencies. Residents are consistently confronted with complex clinical problems that encompass an array of people, places, resources, and environments. The developmental progression of trainees is aided by the use of genograms to conceptualize and teach systems-based practice. In conclusion, the integration of systems thinking into clinical practice supports a comprehensive and multimodal treatment paradigm.

Adaptogenic Herbs: A Promising Adjunctive Treatment in Psychiatric Practice

Chair: Lila E. Massoumi, M.D.

Presenters: Jessica Gannon, M.D., Patricia Lynn Gerbarg, M.D., Richard Paul Brown, M.D., K. N. Roy Chengappa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) • Define what is meant by “adaptogen”; 2) • Describe five adaptogens most useful in psychiatric practice; 3) • Integrate *Rhodiola rosea* in clinical practice; 4) • Evaluate the clinical trial data regarding the use of *Ashwagandha* in Schizophrenia or Bipolar Disorder; and 5) • Describe how *Maca* can be used to treat SSRI-induced sexual dysfunction, and to enhance cognitive and athletic performance.

SUMMARY:

This session will review the evidence base of five botanical adaptogens: *Rhodiola rosea*, *Eleutherococcus senticosus*, *Schisandra chinensis*, *Withania somnifera* (ashwagandha), and *Lepidium Myenii* (maca). Preliminary evidence suggests these herbs are safe and efficacious for treating disorders commonly encountered in psychiatric practice, including *R. rosea* for fatigue, life stress, and depression, *W. somnifera* for bipolar disorder, anxiety, and schizophrenia, and *L. Myenii* for antidepressant induced sexual dysfunction. The term adaptogen was introduced in 1959 to describe substances that increase the “state of non-specific resistance” of an organism under stress. Adaptogens have been proposed to act as mild stress “vaccines” by inducing stress-protective responses. The molecular mechanisms that contribute to adaptogen effects on neuroendocrine regulation of the HPA axis may include molecular chaperones Hsp70 and NPY, membrane-bound G-protein-coupled receptors and G-protein-signaling pathways, regulation of cyclic adenosine monophosphate and protein kinase A, and G-protein-signaling phosphatidylinositol and phospholipase C pathways. Dr. Massoumi, chair of the APA Caucus on Complementary & Integrative Medicine (CIM), will introduce this session. Choosing best quality supplements, risks, benefits and augmentation strategies will be discussed. Resources for further learning will be provided.

Addressing the Mental Health Needs of Survivors of Intimate Partner Violence (IPV) in the Community

Chairs: Mayumi Okuda, M.D., Elizabeth M. Fitelson, M.D.

Presenters: Rosa Regincos, Obianuju Jennifer Berry, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the common barriers to mental health care for Intimate Partner Violence (IPV) survivors; 2) Discuss findings from the evaluation of a program that integrates mental health services with community based ones for IPV survivors; 3) Summarize clinical, legal and training recommendations that can improve access to care for marginalized IPV survivors; and 4) Describe the rationale for a multi-specialty collaborative model that effectively treats IPV survivors’ multiple needs

SUMMARY:

Intimate Partner Violence (IPV) is a major public health problem that results in a wide range of short and long term adverse mental health consequences. In the general population, approximately 20% of individuals that experience IPV within a year develop a new psychiatric disorder. IPV survivors compared to those free of IPV are four times more likely to attempt suicide at some time in their lives. In selected samples such as domestic violence shelters, the prevalence of PTSD and MDD has been reported to be as high as 84% and 61%, respectively. IPV survivors often feel misunderstood, unsupported and even blamed when they interact with the mental health care system. Such negative experiences can perpetuate a damaging cycle of re-victimization and mistrust. Providing trauma-informed care can positively impact the engagement of IPV survivors in treatment. In response to these barriers, we piloted a program to integrate psychiatric and psychological care into the Family Justice Center (FJC). The FJCs are national non-profit organizations that provide legal and other advocacy services for IPV survivors in one location (a “one-stop shop”). FJCs serve survivors of all ages, genders and sexual orientations, regardless of citizenship status or relationship status with their abusers. This presentation will illustrate lessons learned

throughout the development and expansion of this program, while focusing on its accomplishments and challenges. The presentation will also describe the findings of our program evaluation as well as our future directions. It will also provide a platform for discussion on methods to increase awareness and training on IPV and non-combat trauma and how to enhance the national capacity to provide mental health services for this underserved population. This symposium will be presented by a team of professionals in the fields of advocacy, social work, psychology and psychiatry who have experience working with IPV survivors and their families. At the conclusion of the symposium, participants will discuss practical strategies that can improve access to care, while learning about a model that provides integrated services to IPV survivors and other non-combat trauma survivors.

Advancing Outreach Psychiatry Through Collaborative and Integrated Care: Innovations Using Best Practices in Implementation and Systems Planning

Chairs: Allison Crawford, M.D., Ph.D., Sanjeev Sockalingam, M.D.

Presenters: Eva Serhal, M.B.A., Donald M. Hilty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe current models of psychiatric outreach services to rural and underserved areas, including fly-in/drive-in, televideo, Project ECHO, and ehealth and the evidence for each; 2) Outline how to utilize a health-systems approach to increase access to effective, community-specific care; 3) Consider the role of technology in advancing access to stepped and collaborative care with the primary care team; and 4) Implement a quality framework to assess outreach

SUMMARY:

Across Canada and the United States, the burden of mental health disorders tends to be higher in rural and remote regions; yet, these regions tend to struggle with limited access to mental health care. During this session, existing outreach strategies will be reviewed and discussed, as well as novel approaches to providing effective care across North

America. The panel will then outline the current, interdisciplinary, stepped approach to care utilized by their team. This approach integrates modalities of in-person, telehealth (telepsychiatry), telementoring (Project ECHO), and e-behavioral health (e-BH) to increase access to and efficiency of mental health services. A continuum of in-person and e-BH care provide versatility to health systems by enabling more patient points-of-entry, matching of patient needs with provider skills, and helping providers work to their full scope of practice. Our panel will also discuss merging health systems research which suggests that poor systems planning can limit the potential impact of these outreach services (e.g., inadequate needs assessment and evaluation; inequitable allocation of resources; lack of integration among service providers). An integrated approach requires consideration of impact and health systems organization at multiple levels, including: provider engagement and capacity, practice change, patient outcomes, population health, and economic modelling. In this session we will work through cases that allow consideration of the relevant literature, while also providing practical opportunities to consider the critical aspects of systems planning, implementation, capacity building, community engagement and evaluation, which are necessary for building an effective clinical outreach service. Crawford will discuss a recent systematic literature review, updating the last 2002 Cochrane review of outreach specialist services. She will also provide an overview of the Northern Psychiatric Outreach Service in Canada, which provides service to remote and underserved areas across Ontario and Nunavut, including the use of clinical models of collaborative care, and use of telepsychiatry. Serhal will draw on her recent research using population health data to consider how this data can guide systems planning. She will also discuss principles of program implementation, drawing on our recent research in implementation of ECHO Ontario Mental Health, and suggest a framework for assessing outreach strategies. Sockalingam will describe our successful adaptation of Project ECHO for mental health and will lead the discussion of evaluation and quality improvement. Hilty will discuss the effectiveness and practical dimensions of an e-BH spectrum of care, and will provide the United States context based on his work in outreach in California.

Crawford will lead a case discussion of principles and practices of community engagement, including cultural considerations.

Advocating for Refugees: Re-Framing the Role of Mental Health Professionals and Trainees in Refugee Mental Health

Chair: Sophia Banu, M.D.

Presenters: Kaitlyn Marie Carlson, Sally Huang, Adam Goldberg, M.D., Mark Yurewicz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) ? Demonstrate a basic understanding of the qualifications for refugee status and the process of refugee resettlement; 2) ?

Identify common mental health problems that are prevalent in refugee populations; 3) ?

Understand the importance of fostering relationships with refugee communities, support services, and local businesses when engaging the refugee community and designing interventions; and 4) ?

List multiple ways that medical trainees can engage refugee communities to improve refugee mental health such as health fairs, mental health education classes, and mindfulness interventions

SUMMARY:

Refugee populations in America suffer from an increased burden of mental illness and low health literacy. They also can face structural barriers when attempting to access health care including psychiatric care. Harris County in Houston has resettled 8,500 refugees in the past 3 years, from 12 different countries. Starting in 2015, a group of medical trainees and psychiatrists from Baylor College of Medicine has built partnerships with resettlement agencies and refugee communities that have allowed us to assess refugee health needs and implement several interventions for the Houston refugee population, including annual health fairs, Wellness education classes, and a narrative medicine project, aimed at overcoming these barriers. Our work has shown that medical professionals and trainees can engage with refugees outside of a strictly clinical setting in ways that improve the health of refugees and teach trainees about the far-reaching implications of the social determinants of health and special considerations for refugee health.

In this session, we will provide basic information about who is a refugee, their journey, misconceptions about refugees, the refugee resettlement process, and the mental health risks. We will go on to provide examples of ways to engage refugee populations as medical professionals and trainees taken from our work with Houston's large refugee population. Then, we will provide small groups with excerpts from interviews we have conducted with re-settled refugees for discussion about barriers to care and opportunities for intervention. Participants will be encouraged to share their own work with local refugee populations and brainstorm further avenues for engagement and service.

Beacons of Light: Teaching Psychiatry to Non-Psychiatrists

Chair: Suzie C. Nelson, M.D.

Presenters: Matthew James Baker, D.O., Mark E. Hubner, M.D., Randon Scott Welton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop the skills to teach psychiatric subject-matter to non-medical audiences, using specific examples of consultation to other medical, local community, and global community professionals.; 2) Demonstrate how audience assessment and audience culture impact the delivery of information in an acceptable and usable manner.; and 3) Discuss ways clinicians can increase their current clinical reach and consider delivering mental health education in their own spheres of influence.

SUMMARY:

With a growing awareness that unmet mental health needs have created a public health crisis, psychiatrists are poised to be in a unique leadership position. Other professionals, both medical and non-medical, look to us as beacons at times, possessing both the knowledge and understanding necessary to shine a light on problems such as mental health stigma, misconceptions about treatment effectiveness, and lack of appropriate access to mental health care. We communicate this knowledge and understanding in the clinical setting on a regular basis, but we can also do this on a larger scale. Real change can be implemented throughout

systems when we find ways to broaden our reach beyond our clinic doors. Presentations will include panelist experiences shining this beacon of light in communities both local and global. Each panelist has had the unique experience of teaching mental health in a variety of settings and will present these for discussion. 1) In our own medical communities, we present efforts to achieve integration of behavioral health practice into primary care clinics via provision of skills in diagnosis and use of evidence-based treatment algorithms to extend the reach of mental health care. 2) In school systems we can perform not only school-based mental health services, but also implement programs for consultation with school administrators and teachers for the purposes of fostering resilience among students, implementing bullying prevention, and providing psychoeducation to combat stigma among youth. 3) Among community first responders we provide guidance on basic use of disaster mental health interventions such a psychological first aid. 4) Around the world, unique experiences consulting with government leaders and medical professionals in other countries demonstrate that education about mental health diagnosis and treatment, in addition to programming to implement disaster mental health skills or wellness programs, can offer ways forward in their own health systems. A critical lesson learned from all of these experiences is that evaluation of and consideration for the culture of the audience is key to making progress toward these goals. Psychiatrists can make use of the skills we use in clinic every day, particularly when consulting with a group of professionals and leaders about programs that encourage change. A basic understanding of and ability to translate skills for empathy, active listening, and group dynamics all serve us well when collaborating with groups of leaders across the settings that are presented. The challenge for all of us is to apply these same principles to the communities where we live and work. Discrepancies in availability of care, traumatized and suffering individuals, cultural and societal norms that impact health care, and limited resources are barriers to be overcome everywhere.

**Before, During, and After the Suicidal Moment:
Stress, Suicide, and Community Intervention**

Chair: Kevin M. Malone, M.D.

Presenters: Aoife O'Donovan, Ph.D., Seamus McGuinness, Ph.D., Abbie Lane, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand stress-related biological factors contributing to risk and protective factors for suicidal depression; 2) Demonstrate the potential of experience sample modelling to learn more about suicidal moments during a depressive episode; and 3) Demonstrate the potential of innovative arts-science approaches to establishing and evaluating community interventions around suicide

SUMMARY:

Suicide is a significant and stigmatized public health concern. The traditional approach to suicide research has been uni-disciplinary and frequently solitary with the associated limitations of such an approach. Few suicide intervention and prevention studies have considered interdisciplinary approaches including biology, psychology and humanities to obtain and share new knowledge and understanding around suicide and its aftermath. Suicidal moments include varying frequency, intensity and duration of suicidal ideation and acts. Most of these suicidal moments are non-fatal and fleeting, with limited psychological consequences. However, suicidal acts are occasionally fatal, with impacts for family, community, culture and society. This session aims to engage participants about three strands of innovative biologic and humanities research around the emergence of the suicidal moment and its cascading impacts. Participants will learn about stress-related biological markers, particularly inflammatory markers, and their potential role in suicidal thinking during a depressive episode. The Experience Sampling Method (ESM) is a research procedure for studying what people do, feel, and think during their daily lives, which our group has applied to the study of depression, pro-inflammatory biological markers and the emergence of suicidal moments. We will interactively demonstrate the ESM method and how it can be applied to understand the intra-day dynamics of depression and suicidal ideation. We will discuss innovative science-arts methods to engage communities in the aftermath of a fatal suicidal moment. We will

provide movie footage of one such community intervention with arts-science interdisciplinary methods (Lived Lives) which is included in Ireland's National Strategy for Suicide Prevention (2015-2019). An interactive panel discussion will follow with a clinical psychiatry researcher, a visual arts researcher and suicide research fellow, a psychoneuroimmunology expert and session participants focusing on how the suicidal moment can be interrogated and understood from traditional and non-traditional vantage points, embracing an inclusive research approach with expertise from the fields of psychiatry, psychology and arts and humanities.

Behavioral Addictions: The Latest Meme or a Real Thing?

Chairs: Shram Dinesh Shukla, M.D., Meghan Elizabeth Quinn, M.D.

Presenters: Timothy W. Fong, M.D., Elie Aoun, M.D., Robert Rymowicz, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify five (5) behavioral addictions for possible consideration of inclusion in the DSM: Eating, Internet, Gaming, Sex and Shopping.; 2) Compare and contrast the epidemiology and neuro-biological mechanisms of behavioral addictions.; 3) Understand the similarities and differences between proposed criteria for these conditions and established criteria for substance use disorders by the DSM and even Gaming Disorder by the ICD.; 4) Consider the application of various available and emerging treatments.; and 5) Identify the ethical issues associated with such a classification of diagnoses.

SUMMARY:

The DSM's conception of addictive disorders continues to evolve. Using drugs and alcohol as a model for addictive disorders, our understanding of the relationship between neurobiological changes and behavioral compulsions expanded. We now have a detailed understanding of the neurocircuitry of addiction and how it relates to the phenomenological presentation of what we now term Substance Use Disorders. The question now becomes: should this understanding apply to more

than just recreational substances? The authors of DSM-5 set the precedent by including gambling disorder, the first behavioral addiction. As our understanding of the science continues to evolve, is it time to formally diagnose and treat a new set of behavioral addictions? In this workshop, we aim to evaluate five (5) potential behavioral addictions based on the body of data that has been published: Eating, Internet, Gaming, Sex, and Shopping.1-5 We will also examine the epidemiological data regarding these potential conditions to highlight the concerns with such data: the various methods utilized in combination with the lack of unified criteria raise flags about its accuracy. The workshop will then analyze the criteria established by the DSM-5 for substance use disorders and gambling disorder and the upcoming proposed criteria for Gaming Disorder in ICD-11. With this in mind, the focus will transition to examining proposed criteria for the above behavioral addictions. We will highlight the challenges relating to the two competing concepts when attempting to determine exact classification criteria: a strictly biological view of addictions versus one defined by a social dysfunction. After briefly discussing researched treatment modalities (both pharmacological and nonpharmacological), the workshop will close by identifying and discussing ethical issues surrounding behavioral addictions at large. By establishing formal diagnoses for these potential conditions, the lack of replicated studies indicating efficacious treatments leaves a significant void in the treatment process, while the medicalization of these conditions risks the promotion of social stigma. More so, at what point do habits or even coping mechanisms become a "disorder" and what are we establishing as the "normal?" On the other hand, these considerations may even be a product of the kind of forward-thinking that results in earlier interventions and better outcomes.

Behavioral Medicine 2.0: The "Behavioral Pharmacy" Model for Health Behavior Change

Chair: Benjamin Emmert-Aronson

Presenters: Steven Chen, Elizabeth Markle

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the extent of the

impact of the leading causes of disability and mortality, including depression, heart disease, diabetes, and cancer; 2) Identify effective behavioral treatment components; and 3) Describe 3 ways of bundling treatment depending on practice parameters

SUMMARY:

Chronic, preventable, behaviorally mediated diseases are by far the largest causes of disability and mortality in our nation, accounting for 75% of our national healthcare spending (Anderson, 2004). While these are often divided into physical health (e.g., cardiac disease, diabetes, cancer) and mental health (e.g., depression and anxiety), the trans-diagnostic comorbidities, and underlying drivers of illness are massive. For example, Medicaid patients with depression have “physical” health costs that are twice as high as those without depression, in addition to mental health costs that are as much as 10 times as high (Melek, 2012). Similarly, patients with “physical” conditions frequently go on to develop mental health conditions (Chapman, 2005). Clinicians attempt to address this, and, across physical and psychiatric diagnoses, make the same four behavioral “prescriptions:” “Eat better, exercise more, reduce your stress, get some social support!” However, these prescriptions lack the clear, integrated, financially-supported delivery system that exists for the delivery of pharmaceuticals: we lack a behavioral pharmacy. Particularly in low-income communities who lack access to the boutique wellness system, and where food deserts are common, instructions for behavior change are essentially a prescription to nowhere: patients fail to make the behavioral changes, and their conditions deteriorate. Utilizing the principles of person-centered design and intentional community to make behavior change easy to implement and socially rewarding, the authors created a “Behavioral Pharmacy,” a democratized delivery mechanism for health behavior change. The Open Source Wellness model consists of a community-based intervention focused on four pillars of health and well-being: exercise, nutritious meals, stress reduction, and social support. The model is adapted for clinical, community, low-income housing, and employee settings, and is delivered in a group format by paraprofessionals, making the intervention both scalable

and cost effective. The authors describe implementation and outcomes from the model, including integration into group medical visits within a large primary care setting, a community-based open-access model, and a low-income housing model. Outcomes include significant drops in depression (via PHQ-9 scores, Cohen’s d’s ranging between -0.9 and -1.6) anxiety, and social isolation, in addition to changes in “physical” health measures such as increased intake of fruits and vegetables, increased exercise, and decreased blood pressure. This interactive, experiential, and dynamic session introduces the rationale, the essential “active ingredients,” and implementation models for the Behavioral Pharmacy model, addressing participant questions throughout. We will close with descriptions of how this can be seamlessly integrated into clinic workflow and EMRs, bundling social determinants of health innovations to address chronic disease at its source.

Beyond Recognition to Prevention: Integrating Techniques to Reduce Risk Measures on Quality Evidence-Based Metrics Into Acute Care Practice

Chair: Renuka Ananthamoorthy, M.D.

Presenter: Jennifer Morrison-Diallo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the elements that comprise proactive strategies to address patient and staff needs in an acute psychiatric setting; 2) Identify strategies to recognize, assess, and plan for management of individuals who are “high risk”; 3) Recognize the wide impact proactive measures have on reducing restrictive interventions on a systems level; and 4) Create individualized person-centered interventions for individuals with significant trauma histories and psychosocial stressors in their lives by utilizing interdisciplinary treatment strategies

SUMMARY:

Individuals presenting to acute psychiatric services display increasing severity of symptoms overlaid with complex trauma and intense psychosocial stressors require “out-of-the-box” thinking and creative interventions to provide effective, person-centered interventions. At NYC Health + Hospitals/Kings County in Brooklyn, NY we use a

variety of proactive interventions to address these high-risk patient needs which include: 1) proactive rounding (occurs two times daily with interdisciplinary team); 2) unit-based interventions such as “patient of the day” and our crisis management system; and 3) individualized behavior interventions and behaviorally based milieu management strategies. The purpose of these proactive interventions were to achieve a reduction in serious incidents, assaults (patient-to-patient and patient-to-staff), and restrictive interventions (4 pt. restraints, IM, manual hold). Our aim was to also increase individuals’ adaptive tools and behaviors resulting in more time spent in the community adhering to their treatment. The combination of these interventions resulted in: 1) a 50% decrease in restrictive interventions (IM/manual hold, 4pt restraints); 2) over 50% decrease in patient-to-patient assaults and patient-to-staff assaults; and 3) an increase in time spent in the community between admissions. Proactive interventions contribute to a safer, more stable milieu in which staff and leadership work together to prevent problems and improve safety and satisfaction. This workshop will present participants with the techniques and lessons with our three step proactive approach and allow them to work together to integrate this into their own practice. Participants in this workshop will work together on creating individualized person-centered interventions by utilization of case examples of individuals who have significant psychiatric diagnoses, trauma histories, and psychosocial stressors. Participants will be able to leave this workshop with strategies for assessment and treatment of individuals with complex presenting behaviors to be able to more effectively meet the constantly changing needs of working with high-risk patients in acute psychiatry.

Brain Changes at the Onset of Bipolar Disorder

Presenter: Stephen M. Strakowski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to define aspects of early course progression in bipolar disorder.; 2) Participants will be able to describe the functional neuroanatomy of bipolar disorder.; and 3) Participants will be able to discuss developmental

aspects to consider in early course bipolar disorder progression.

SUMMARY:

Bipolar I disorder is defined by the occurrence of mania, although depression occurs in >80% of affected individuals, as do a myriad of other affective, cognitive, behavioral and neurovegetative symptoms. These symptoms wax and wane often in different combinations over time so that many individuals with bipolar I disorder are not correctly diagnosed for up to 10 years. This clinical presentation suggests that in bipolar I disorder healthy neural processes that modulate affective, cognitive and risk-reward behaviors are disrupted, creating an unstable, dynamic psychiatric illness. Moreover, mania typically emerges in adolescence or young adulthood. Studies of bipolar I disorder have largely converged to a median age at onset in the range of 15-25 years old across a variety of survey methods, countries and ethnic groups. Once it occurs, mania is a strongly predictive phenotype; more than 80% of affected individuals will experience lifelong recurrent affective episodes. Additionally, long-term outcome studies suggest that the early course of bipolar disorder is progressive. Specifically, periods of euthymia progressively shorten after each of the first several affective episodes ultimately settling into a ‘stably unstable’ course of illness. Moreover, most individuals experience affective, anxiety, cognitive and behavioral symptoms for several years prior to the first manic episode. Together, the age at onset, predictive phenotype and progressive clinical course suggest that bipolar I disorder results from failure to develop healthy neural emotional systems in the transition from adolescence into young adulthood. In this presentation we will review clinical and neuroimaging data to conceptualize a neurodevelopmental model of bipolar disorder.

CANCELED: VA Care IS Community Care: Population-Based Behavioral Health Care for a Most Vulnerable and Underserved Population—Our Nation’s Veterans

Chair: Margo Christiane Funk, M.D., M.A.

Presenters: Rosa Ruggiero, M.S.N., Nicole Miller, Psy.D., Laura Bridges, L.C.S.W., M.P.H., Erin Keller

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize modern theories of population-based health, patient centered medical home, and collaborative care.; 2) Compare and contrast public community behavioral health models with the VA model.; 3) Discuss strategies and develop a plan to optimize population coverage, continuity of care, and Veteran experience using a stepped-care approach through the continuum of VA behavioral health services.; 4) Describe VA-specific outcome measures (Strategic Analytics for Improvement and Learning, SAIL) and financial reimbursement model (Veterans Equitable Resource Allocation, VERA).; and 5) Apply knowledge of SAIL and VERA to optimize implementation of population-based behavioral healthcare at the VA facility level.

SUMMARY:

This session has been canceled.

Careers in Addiction Psychiatry: From Residency to Fellowship and Beyond

Chair: Timothy W. Fong, M.D.

Presenters: Michael Hoefer, M.D., Carla B. Marienfeld, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe a wide range of career opportunities in Addiction Psychiatry and the profession; 2) Explore the participants' own decision-making process regarding career options; 3) Assess how the treatment of substance use disorders fits within the general practice of psychiatry; and 4) Create mentor networks between attendees, presenters and AAAP members

SUMMARY:

The career possibilities in Addiction Psychiatry are very diverse and becoming more so. Psychiatrists have a wide range of interest in lifestyle goals and working style. It is no surprise that the decision trainees and early careers make regarding long term career decisions are difficult and complex. The APA recently surveyed psychiatry residents about their interest in a career in Addiction Psychiatry. Many trainees noted the lack of information during residency about career opportunities in Addiction

Psychiatry, including concerns about the availability of stable employment, interesting positions, and competitive salaries. This workshop is organized to address these concerns and to provide specific information about the range of career opportunities in this field. Each speaker will discuss about lessons learned about their career choices. An interactive session with the audience will proceed with ample time for questions and answers. This workshop is particularly relevant to trainees and early career addiction psychiatrists. Participants will evaluate and recognize a wide range of career opportunities in Addiction Psychiatry and the professional gratifications associated with this type of work. This workshop is to help residents, fellows, and early careers determine if Addiction Psychiatry meets their needs and furthers their career goals. Expert speakers will describe a variety of career options including private practice, and careers that primarily focus on training and mentoring, research and administration. Speakers will discuss their own decision-making process and give personal accounts on how they chose their area of specialization. They will also describe what their daily work is like and what drew them to their current work settings to help the trainees develop strategies for fostering successful careers in Addiction Psychiatry. Finally, they will offer their own insight on what they wish they'd done differently.

Channeling Your Inner Risk Manager: Video Training for Psychiatrists and Residents

Chairs: Richard Calvin Holbert, M.D., Jacqueline A. Hobbs, M.D.

Presenters: Amanda Mihalik-Wenger, M.D., Britany Griffin, Donna Vanderpool, J.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Cite the scope and costs, in dollars and other resources, of medical errors in psychiatric practice; 2) Categorize the leading medical errors in psychiatry; 3) Review innovative training videos in psychiatric risk management; and 4) Apply knowledge and skills of risk management to psychiatric practice

SUMMARY:

Medical errors cost the United States approximately 20 billion dollars annually. It is estimated that 10% of all deaths occur by medical errors, making it the third leading cause of death. Medical errors also cause significant morbidity for possibly millions of patients. Physicians suffer psychologically from medical errors with feelings of guilt and real/perceived effects on reputation, and economically through medical malpractice suits. In psychiatry, there have been multi-million dollar judgments. Summary data on the type and number of cases and the range of verdicts and settlements will be reviewed. Psychiatric practice is not without contribution to medical errors and patient morbidity and mortality. The APA Committee on Patient Safety has identified six areas most commonly associated with errors in psychiatry. The six areas are suicide, medication errors, aggression, falls, elopement, and medical comorbidities. Psychiatrists and residents in training need to understand these areas and gain knowledge and skills in preventing errors, developing a patient safety culture, and mitigating practice risk. The creation of a patient safety culture reduces medical errors, increases staff morale, and enhances the efficiency of healthcare. For individual psychiatrists this leads to enhanced job satisfaction, less malpractice claims, greater performance from staff, and the ability to increase services provided and subsequently increased income. We will review the literature on the positive effects on individual physicians of a patient safety culture and weigh them with any possible negative consequences of such a culture. Major aspects of psychiatric practice risk management will be reviewed. We will review examples of cases with major judgment awards after medical errors in psychiatry. We will describe the role of informed consent, practice guidelines, policies and procedures, disclosure, suicide risk assessment, and documentation in mitigating risk. We have developed innovative training videos that will engage psychiatrists and residents in learning about medical errors, patient safety culture, and practice risk management. These videos will be reviewed and serve as a basis for discussion and self-assessment of learning. The overall goal is to train psychiatrists and psychiatry residents to not only think like clinicians but also at least a little like a risk manager to optimize patient safety and their practice.

Cognitive Behavior Therapy for Personality Disorders

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Specify and conceptualize difficulties in treating personality disorder patients; 2) Engage personality disorder patients in treatment; 3) Use the therapeutic alliance to achieve treatment goals; 4) Describe advanced cognitive and behavioral techniques, including modifying the meaning of adverse childhood experiences; and 5) Facilitate cognitive change at the intellectual level and emotional level

SUMMARY:

A number of studies have demonstrated the efficacy of Cognitive Behavior Therapy in the treatment of patients with personality disorders (e.g., Fournier et al., 2008; Davidson et al, 2006; Matusiewicz et al., 2010). The conceptualization and treatment for these patients is far more complex than for patients with acute disorders such as depression and anxiety. Therapists need to understand the cognitive formulation for each of the personality disorders. They need to be able to take the data patients present to develop individualized conceptualizations, including the role of adverse childhood experiences in the development and maintenance of patients' core beliefs and compensatory strategies. This conceptualization guides the clinician in planning treatment within and across sessions and in effectively dealing with problems in the therapeutic alliance. Experiential strategies are often required for patients to change their core beliefs of themselves, their worlds, and other people not only at the intellectual level but also at the emotional level.

Combat Social Inequity: Opportunities for Direct Policy Action in Residency Training Programs

Chairs: Enrico Guanzon Castillo, M.D., Nichole I. Goodsmith, M.D., Ph.D.

Presenters: Katherine Gershman Kennedy, M.D., Jeff Coots, Colin David Buzza

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least 2 educational strategies for increasing psychiatry trainees' awareness of social and structural inequities in their communities; 2) Identify at least 3 educational strategies that prepare psychiatry trainees to be effective advocates for policies to reduce social and structural inequities; and 3) Identify at least 2 strategies for the development of partnerships between residency training programs and policymakers

SUMMARY:

Psychiatry residents are poised to be effective advocates for political change. Residents' status as physician-trainees and their first-hand experiences witnessing health and social inequities position them to be desirable collaborators with legislators and other policy leaders. In this time of rapid social and political flux, advocacy has the potential to enhance residents' sense of self-efficacy and strengthen their belief in their ability to be successful at effecting change. Studies have shown associations between increased self-efficacy and greater job satisfaction and decreased burnout. Opportunities within psychiatric residency education for political advocacy can help residents translate their growing medical expertise into social and policy action, preparing them for careers as physician leaders. This workshop will highlight the growing activities of 3 psychiatry residency programs that train and involve residents in direct political action. Each program uses different modalities to involve residents in advocacy. Drs. Castillo and Goodsmith from UCLA will describe an educational series that pairs discussions of health services/policy research with direct advocacy around a current event, identifying residents' actions that can be accomplished immediately as well as short- and long-term advocacy and public service opportunities. Dr. Kennedy from Yale will describe their residency program's advocacy curriculum, which she co-directs, within Yale's Social Justice and Health Equity Curriculum. Dr. Kennedy's curriculum trains residents in key advocacy skills, including how to collaborate with state legislators, identify useful clinical and research data for use in advocacy initiatives, present oral and written testimonies, and write for lay audiences. Dr. Seal from UCSF will describe their efforts, together with their residents,

to partner with state legislators on a bill to promote careers in public and community psychiatry. Mr. Coots from the policy-academic-community consortium From Punishment to Public Health (P2HP) will lead a role play exercise to demonstrate strategies he employs to train physicians to be effective advocates. He will describe specific examples of his P2HP's advocacy efforts in New York City for system-level preventive interventions to reduce incarcerations and enhance public health and safety. Group discussion will focus on engaging audience members in strategies to encourage mental health policy action in their programs and institutions.

**Creating Impact at the District Branch Level:
Lessons Learned From Illinois**

*Chair: Hossam M. Mahmoud, M.D., M.P.H.
Presenters: Joshua B. Nathan, M.D., Meryl Sosa*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize different strategies to create impact at the district branch level; 2) Appreciate the role of advocacy in shaping legal and legislative frameworks at the state level; 3) Understand approaches to enhancing physician well-being at the district branch level; 4) Identify ways to enhance member engagement; and 5) Discuss the interplay between district branch advocacy, membership engagement and physician well-being

SUMMARY:

Over the past several years, changes to the healthcare system in the United States have given rise to multiple challenges that have impacted stakeholders, such as healthcare facilities, insurance providers, patients and physicians. Mental health is no exception; psychiatrists and the field of psychiatry overall have been facing increasing challenges. Some of these challenges include scope of practice issues, mental health parity, changes in reimbursement models, the shortage of psychiatrists, the ongoing high service care gap, increased demand for mental health services and an increase in physician burnout rates. Such difficulties highlight the indispensable roles of professional associations, such as the American Psychiatric Association (APA) and APA district branches (DBs);

key initiatives of APA have included advocating for mental health, psychiatrists and our patients, as well as providing educational, social and professional support to members. In this session, we discuss the important roles of DBs, and we highlight the need to continue to expand such roles and to coordinate efforts and share experiences to enhance their impact at the local level. In doing so, we focus on the experiences and lessons learned from the Illinois DB, the Illinois Psychiatric Society (IPS). Accordingly, we highlight key past, current and planned initiatives by IPS, in the areas of member engagement, mental health advocacy, and physician well-being. We start by discussing different approaches to member outreach, engagement, recruitment and retention. Next, we discuss initiatives that highlight the role that DBs can play in shaping state laws and regulations that affect mental health, psychiatrists and patients. We discuss advocacy, including legislator engagement, participating in state committees and advisory councils, and introducing, reviewing and influencing healthcare bills. Furthermore, we highlight strategies at the DB level to enhance member well-being, decrease administrative burden, combat burnout and fight the stigma of mental illness among physicians. The session will include three short presentations by the IPS President, the Executive Director, and the President-Elect and IPS Newsletter Editor, followed by a short Q&A after every presentation. The session will then dedicate about twenty minutes to an interactive discussion on the interplay between advocacy, initiatives on physician well-being, and membership engagement at the district branch level. The discussion is meant to share the experience of IPS and to solicit experiences from other DBs on innovative ways to create positive impact at the local level.

Creating the National Curriculum in Reproductive Psychiatry

Chair: Sarah M. Nagle-Yang, M.D.

Presenters: Lauren M. Osborne, M.D., Priya Gopalan, M.D., Neha Hudepohl

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the educational gap in reproductive psychiatry within US psychiatry

residency training programs.; 2) Summarize the National Curriculum in Reproductive Psychiatry project.; 3) Develop ideas about how the national curriculum project may augment reproductive psychiatry training for individual residency training programs.; and 4) Examine the feasibility of carrying forward the national curriculum project and identify potential barriers to implementation within residency training programs.

SUMMARY:

Over the past three decades, there have been substantial advances in our understanding of the mental health of women during times of reproductive transition. National policies favoring inclusion of women into clinical research have resulted in dramatically expanded knowledge about Reproductive Psychiatry, a specialized field of medicine that seeks to understand and treat mental health disorders related to female reproductive stages. This is evidenced by the growth of international professional societies, has influenced public policy initiatives, and is increasingly disseminated into clinical practice. Specialized clinical programs span the treatment continuum from consultation and outpatient programs, to partial hospital and inpatient settings. While there is no doubt that such programs provide outstanding care, they cannot begin to keep up with clinical demand. Unfortunately, the education of psychiatrists about reproductive mental health has lagged behind advances in research, public policy initiatives, and innovative models of clinical care. In survey of residency training directors published in 2017, findings indicated that training opportunities in this field vary widely between residency programs. Only 59% of included programs reported any required didactic teaching in reproductive psychiatry, and when didactic time was required, most programs allotted 5 or fewer hours for the field as a whole across all four years of residency. Clinical exposure to the field was often dependent on whether or not female patients on non-specialist services happened to be pregnant or perimenopausal. Respondents to our survey indicated that the primary barriers to including or increasing reproductive psychiatry exposure within their programs were lack of time and lack of qualified faculty content experts. This dearth of

reproductive mental health education has had problematic consequences for women patients. There is clear need to ensure all psychiatrists acquire basic knowledge and skills in reproductive psychiatry to ensure competent care of this vulnerable group of patients. This workshop will introduce the audience to the work of the National Task Force on Women's Reproductive Mental Health (NTF), which has been working for the past 5 years to collect information about the current state of residency education in reproductive psychiatry and to propose new training standards. Presenters will summarize the work of the NTF, unveil a pilot version of the first six interactive online modules of our National Curriculum on Reproductive Psychiatry (NCRP), and use interactive methods to obtain audience feedback to help guide our next steps. Feedback gathered in this workshop will be used to create solid suggestions for revisions to the NCRP and for the dissemination and adoption of the curriculum.

Danger and Duty: The Clinician's Dilemma in Duty to Protect Cases

Chair: Jacqueline Landess, M.D., J.D.

Presenters: Alan Robert Felthous, M.D., Brian James Holoyda, M.D., M.B.A., M.P.H., Amanie Salem, D.O., M.P.H., Amir Mohebbi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify basic jurisdictional differences in duty to protect laws; 2) Understand recent state court cases, including Volk v. DeMeerler, and their impact on a clinician's duty to protect.; 3) Apply the law of the relevant jurisdiction in working through example duty to protect cases; and 4) Identify specific resources which will assist the clinician in understanding and applying duty to protect law in his/her state or jurisdiction

SUMMARY:

The 1969 murder of Tatiana Tarasoff and the litigation which followed resulted in a landmark decision by the California Supreme Court known as the Tarasoff principle. The California Court defined a clinician's legal duty to warn or protect potential victims of a patient's threatened violence. In ensuing years, the Tarasoff decision was adopted in some form by most states in the United States. However,

there is great jurisdictional variability in the language, interpretation, and application of this body of law. Some courts have further expanded Tarasoff to include even unidentified potential victims of a patient's violence in absence of a specific threat, and the recent case of Volk v. DeMeerler from Washington state will be highlighted as an example. The variability in the application and interpretation of duty to protect law often proves confusing to the mental health clinician, and the usual advice is to consult an attorney if questions persist. While this may indeed be the most prudent path in some cases, many clinicians would be able to confidently address potential patient violence in their practice if they understood and were able to apply the relevant law of their jurisdiction. Our intent in this session is to enhance clinicians' confidence and competency in dealing with challenging duty to protect cases. Participants should leave the session with an understanding of how to access and apply the law of their jurisdiction, and when to seek additional counsel. Our session will discuss the basic differences between Tarasoff laws throughout the U.S. and guide clinicians through a general template to follow when faced with a patient who threatens violence. These threats may be specific or vague and the target of the patient's violence may not be readily identifiable. During our session, we will demonstrate key principles using interactive media, such as two short video vignettes (approximately three minutes in length) of common duty to protect scenarios a clinician might face in practice. Participants will view these vignettes and discuss in small groups. The presenters will then guide the group discussion in applying the relevant case law of the jurisdiction to determine appropriate next steps or actions. The session will conclude with a summary of relevant resources clinicians may access to increase their knowledge and confidence in dealing with duty to protect cases, and sufficient time for questions from the audience.

Dazzling Gods and Struggling Humans: A Report on Mental Health in Elite Athletes From the International Olympic Committee

Chairs: Claudia L. Reardon, M.D., Brian Hainline, M.D.

Presenters: Antonia L. Baum, M.D., Alan Currie, M.D., M.Phil., David R. McDuff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe why elite athletes have sport-specific risks for mental illnesses; 2) Describe the epidemiology and unique manifestations of mental health disorders, especially mood disorders, eating disorders, and substance use disorders, in elite athletes; 3) Understand how treatments for mood disorders and substance use disorders may be both similar to and different from treatments for these conditions in the general population; 4) Appreciate that there are individual level treatments as well as systemic interventions to address mental health symptoms and disorders in elite athletes; and 5) Provide recommendations for how sport can serve as a subculture for improving mental wellness and mental health treatment-seeking in society

SUMMARY:

It might appear that elite athletes are relatively protected from mental health symptoms and disorders, given their physical fortitude and impressive accomplishments on the field or court. However, increasing epidemiologic reports describe the prevalence of many mental health symptoms and disorders in this population at or above the corresponding rates in general cohorts. Recognizing the importance of the issue, the International Olympic Committee (IOC) convened a workgroup in fall 2018 on the topic of mental health in elite athletes. The workgroup consisted of 27 experts and elite athletes from 6 continents, and was charged with producing a consensus statement on mental health in elite athletes. This presentation will feature the Co-Chairs of that workgroup, Brian Hainline, MD (Chief Medical Officer of the National Collegiate Athletic Association) and Claudia Reardon, MD, together with three other participants from the IOC workgroup, presenting an international perspective on highlights and controversies of the group's work. Their work represents high-level systematic review of the literature, at a breadth and depth never undertaken in prior published reports. While the group's work targeted elite athletes (defined as Olympic, professional and collegiate athletes),

themes have application across the spectrum of sport participation, ranging from recreational exercisers to Olympic gold medalists. Specifically, the presenters will address the prevalence of and risk factors for mental health symptoms and disorders in elite athletes. If elite athletes are so accomplished and revered, why are they at relatively high risk for mental health symptoms and disorders? Presenters will first address mood disorders in elite athletes, including the challenges of distinguishing overtraining syndrome from depression, the increasing evidence base for whether individual or team sport athletes are at greater risk for mood disorders, and whether media implications that athletes who suffer concussions in certain sports are at greater risk for suicide are based in fact. Eating disorders in elite athletes will be addressed next. Specifically, presenters will describe the difficulty distinguishing eating disorders from adaptive nutrition in high-level athletes, controversy surrounding the concept of the Female Athlete Triad as potentially outdated and better conceptualized as Relative Energy Deficiency in Sport (RED-S), and myth versus fact surrounding impact of disordered eating on athletic performance. Substance use disorders in elite athletes represent the third major diagnostic category to be covered. Data will be shared regarding which substances elite athletes use in higher versus lower rates than the general population, reasons for use, and which sports are at greatest risk. Across diagnostic categories, presenters will address how symptom manifestation and treatment considerations differ in athlete versus general population samples. Finally, creation of an environment that supports mental well-being and resilience in elite sport will be explored.

Difficult Clinical Decisions in Electroconvulsive Therapy Practice

Chair: Keith Rasmussen

Presenters: Teresa Ann Rummans, M.D., Simon Kung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn how to properly select patients for ECT; 2) Learn how to reduce medical morbidity in ECT; 3) Learn how to maximize clinical

efficacy in ECT; and 4) Learn how to minimize side effects in ECT

SUMMARY:

Electroconvulsive therapy (ECT) is still a critical component of modern psychiatric practice. In spite of the development of new neurostimulation technologies, psychotherapies, and medications, approximately 100,000 people in the USA alone receive ECT each year. Over the past decade or so, new ECT techniques have emerged. Additionally, it is critical that the proper patients be selected for this modality. In typical day-to-day ECT practice, difficult decision points are reached whereby the psychiatrist must choose an appropriate course of action. In the proposed General Session, the moderators, Mayo Clinic psychiatrists highly experienced in ECT delivery, will present a series of cases from our practice that highlight clinical dilemmas and difficult choices. For each case, pertinent introductory material will be provided, followed by the clinical choice phrased as a question, followed by enumeration of possible courses of action, followed by group discussion, followed finally by presentation of how we handled the case at Mayo.

Digital Psychiatry: Vaporware or Visionary? A Dialogue on the Data Behind the Technology

Chair: Yener A. Balan, M.D.

Presenter: Neil Leibowitz, M.D.

Discussants: John Torous, M.D., Ravi Hariprasad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand the mental health digital health landscape.; 2) At the conclusion of this session, the participant will be able to understand what apps and platforms are available to physicians and patients and what these apps offer.; 3) At the conclusion of this session, the participant will be able to evaluate the data showing the efficacy of these apps; and 4) At the conclusion of this session, the participant will be able to understand the risks and benefits of using these digital health apps and platforms.

SUMMARY:

There is an increasing desire by health systems and payors to use innovation and technology in healthcare. However, for many psychiatrists digital health and mental health apps remain buzzwords. At this time there has been little technology integrated into mental health care beyond telepsychiatry. Whether it be wearables, online treatment platforms or online ‘case management,’ it seems like a new app or technology platform is coming out every day. Can any of these apps and platforms truly help patient’s? Our session will explore the types of technology available to both psychiatrists and patients. We will give psychiatrists a framework for how to evaluate technology and we will review the data and evidence behind the technology. We will look at how psychiatrists and other clinicians are currently using them as well as the clinical risks and benefits. Our panel will discuss the growing body of literature and evidence behind them as well as the legal implications and risks. After a brief presentation by our panel, we will let APA members' interests guide the discussion in a question and answers format.

Discrimination Against People With Mental Illness

Chair: Claire Henderson

Presenters: Nick Glozier, Georg Schomerus, Nicola Reavley, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. Compare the prevalences of positive and negative responses experienced by people with a mental illness from people in their social networks such as family, employers and health professionals; 2) 2. Describe the relationships between: internalised stigma; attitudes to mental illness; attitudes to mental health professionals; and others’ responses, and help-seeking for a mental illness; 3) 3. Appraise the evidence for effectiveness of an online workplace disclosure decision aid for employees; 4) 4. Review the evidence for effectiveness of regulatory or legislative levers in reducing discrimination for people with depression, anxiety and suicide-related behaviours; and 5) 5. Formulate responses to mental illness discrimination using an organising framework used in diversity training

SUMMARY:

Among the many adverse consequences of stigma and discrimination against people with a mental illness, lack of help seeking and suboptimal engagement with mental health services is one which impairs the effectiveness of psychiatry and mental health care in general. Similarly, nondisclosure of mental illness in the workplace for fear of negative consequences prevents the provision of workplace adjustments in line with equalities legislation. Disclosure can elicit supportive responses as well as negative treatment and avoidance on the part of co-workers and others in a person's social network. Supportive responses include encouragement to seek professional help. However, whether this encouragement occurs and is effective is influenced by attitudes to mental illness, on the part of the affected person and their social network members, and attitudes to sources of professional help including primary care physicians and mental health professionals. Our first speaker in this session, Dr Nicola Reavley will present evidence on the extent to which past or current experiences of avoidance, discrimination or positive treatment predicted current health service use and workforce participation, using data from a national survey and a follow up sample. While this is the first survey to address this question, there have been enough surveys on attitudes to psychiatry and mental health care for a recent meta-analysis, presented by our second speaker Dr Georg Schomerus. Turning to interventions to reduce the impact of stigma on disclosure and help seeking, our third speaker Professor Glozier will present results of a randomised controlled trial of an online disclosure decision aid for employees with a mental health problem who have yet to tell anyone in their workplace. This trial not only used the usual measures of effectiveness of decision aids such as stage of decision making and decisional conflict, but also allowed observation of the impact of disclosure on those choosing to do so. Moving from an individual level intervention to those at the structural level, Prof Glozier will then present a systematic review of the effectiveness of regulatory or legislative levers in reducing discrimination for people with depression, anxiety and suicide-related behaviours. Our fourth and final speaker and session organiser Dr Claire Henderson will present an

overview of the interventions used to reduce discrimination at the interpersonal and structural levels and that on reducing internalised stigma. This overview will identify similarities between interventions for interpersonal and internalised stigma, and potentially effective methods which have been neglected in research interventions. Finally, an organising framework for the selection of intervention types and of outcome measures will be presented, based on one widely used in workplace and higher education diversity training.

Don't Fail to Fail: Strategies for Clear Communication With the Learner in Difficulty

Chair: Carmen E. Wiebe, M.D.

Presenter: Mark Halman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe a framework for working with a learner in difficulty; 2) Implement effective communication strategies with a learner in difficulty; and 3) Be more willing to engage with a learner in difficulty.

SUMMARY:

Clinical teachers are often daunted by the realization that a learner is in difficulty. Reluctance to offend the learner, frustration with the learner for not meeting responsibilities, and fear of having to justify one's actions can make it challenging to address concerns in a timely, supportive and productive way. There is a need to train staff to communicate "bad news" (Dudek, 2005): providing specific skills should help staff engage in, rather than avoid, these difficult conversations. This workshop will introduce three communication techniques to help clinical teachers talk to learners about performance issues, clarify the underlying problem, and begin to negotiate a remediation plan. There is currently no evidence to support any particular set of communication techniques with learners in difficulty. This innovative workshop will introduce three strategies borrowed from Dialectical Behaviour Therapy, a manualised, evidence-based psychotherapy which operationalizes its communication techniques in a concrete, specific way. Removing the strategies from a psychotherapy context allows teachers to improve the clarity and directness of their communication

without crossing a line into “doing therapy”. Facilitators will open the workshop with a role-play demonstrating poor communication. A framework for responding to learners in difficulty will be presented. Communication strategies will be described and then illustrated or practiced via: 1) a video with opportunity to reflect; 2) sample conversations inviting input from the group; 3) whole-group brainstorming, and 4) a paper-sorting exercise in pairs. Facilitators will reprise the opening role-play, this time demonstrating the strategies taught, and invite the group to discuss.

Don't Give Up! Somatic and Psychotherapeutic Interventions for Tough to Treat OCD Across the Lifespan

Chair: Jerry L. Halverson, M.D.

Presenters: Eric Storch, Bradley Riemann, Jennifer Park, Wayne K. Goodman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be able to define treatment refractory OCD across the lifespan; 2) Identify evidence based Psychotherapeutic adjustments to standard treatments when OCD doesn't respond across the life span; 3) Understand evidence based pharmacologic approaches to difficult to treat OCD in adults; and 4) Understand which patients whomight be appropriate for TMS or DBS for OCD

SUMMARY:

Obsessive compulsive disorder is one of the most difficult to treat psychiatric disorders that clinicians face in their practices. OCD is a major cause of disability world wide. This presentation will be a practical and clinically based discussion of the current evidence based treatment for OCD which fails to respond to standard treatments. We will have 5 clinicians experienced in the treatment of refractory OCD. The presentation will begin with discussion of difficult to treat OCD in the child and adolescent population from both a psychopharmacological and psychosocial perspective and recommended treatment adjustments. We will then discuss psychosocial and psychopharmacologic adjustments for adults with refractory OCD. Finally we will discuss somatic treatments for refractory OCD including the recently approved TMS and DBS.

The presentation will conclude with a panel discussion.

Duty to Warn, Duty to Train, Duty to Protect: The Ethical Imperative of Climate Change

Chair: David Alan Pollack, M.D.

Presenters: Arianne Teherani, Ph.D., Michael Foster

Discussant: Lise Conway Van Susteren, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain a clear understanding of the imminent and critical risks to general, mental, and public health posed by climate change; 2) Recognize the validity of the ethical obligation to warn others of the relevant health risks and remedies associated with climate change; 3) Understand, endorse, and be motivated to participate in efforts to educate colleagues, trainees, and the general public regarding the mental health aspects of climate change; and 4) Become aware of and appreciate the acceptability and courage of civil disobedience efforts by some activists to bring broader attention to the risks of climate change

SUMMARY:

Climate change is now widely seen as the greatest threat to public, physical, and mental health now and for the future. This session will briefly describe some of the health risks associated with climate change (CC). We will then discuss the question of relevance and degree of obligation for health professionals to acknowledge and act on the ethical duty to warn others. Although many are now seeing our undeniable obligation to speak out to the general public and to policy makers about climate impacts on health, this task must be particularly clarified and sometimes nuanced to accommodate the ways to best inform and educate individual patients, especially those with psychiatric conditions. There is a rapidly growing realization of the importance of providing evidence-based and public health oriented training regarding all the health consequences of CC. This must address recognition, diagnosis, treatment, and prevention components of climate derived health conditions with differential emphasis on the conditions that are most relevant to each type of practice and specialty. Training must also be provided throughout the continuum of

educational venues, from undergraduate medical training to postgraduate residency and research education to continuing education for all active health professionals. Finally, we will discuss the merits, impacts, feasibility, and legal and mental health aspects of engaging in conscientious protectionism, a form of civil disobedience intended to shift public opinion and policies by raising awareness of the severity and extent of the threats of CC.

Effective Integration of Primary Care and Behavioral Health: The Secret Sauce

Chair: Lori E. Raney, M.D.

Presenters: Lori E. Raney, M.D., Gina Lasky, Ph.D., Maria Garcia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the roles and interplay of the core members of the integrated care team; 2) Discuss the challenges to core team dynamics necessary for effective integrated care teams; 3) List key tasks and workflows necessary for outcome changing integrated care; and 4) Understand the key attributes of the core team members that can assist in hiring and retaining qualified staff

SUMMARY:

Integrating primary care and behavioral health may on the surface seem like a simple undertaking to accomplish: place well trained licensed behavioral health staff into a primary care office and have the primary care providers refer patients to them who have been identified with behavioral health concerns. What could go wrong, right? In fact the process is quite intensive and must adhere to a rigorous re-alignment of workflows that interject key processes that can seem very foreign to the typical primary care office environment. These include the key tasks and processes that are known to result in positive outcomes including implementing measurement-based care, using a registry to track a population, frequent outreach to patients between visits, and psychiatric consultation on a routine basis. Beyond this list of tasks lies another layer of key characteristics of the actual team that are quite often, and unfortunately, overlooked until the

process of integration begins to founder. This is the so-called “secret sauce” of integration that will be discussed in this session. From the need for a primary care provider “champion” to an “engaged” psychiatric provider and a well-defined role for the behavioral care manager, these elements are turning out to be as important as the outcome producing key tasks. Mirroring the full integrated care team, the presenters will include a psychiatric consultant (Lori Raney, MD), a behavioral care manager (Gina Lasky MD) and a primary care provider (Maria Garcia, MD) who have lived and breathed integrated care for a combined 20 plus years. Their experience in designing, and re-designing, teams as obstacles presented themselves, has led to an appreciation of the necessity of paying attention to the attributes the team members themselves bring to the journey. After a brief description of the models they have worked in and the research on the elements of the “secret sauce” they will provide a panel discussion with the audience to not only describe in more detail some of their experiences but also hear from the audience what they have experienced and then have the entire group share and brainstorm ideas for overcoming these challenges.

Emerging Treatment Strategies for Mood and Anxiety Disorders

Chair: Stefan Kloiber

Presenters: Yuliya Oleksandrivna Knyahnytska, M.D., Nazanin Alavi, M.D., Alpna Munshi, M.D., Ishrat Husain, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To compare traditional notions of mental health delivery with recently emerging approaches; 2) To demonstrate new techniques and approaches for treatment of depressive and anxiety disorders; and 3) To provide an overview of current evidence of emerging treatment approaches for assessment, treatment and monitoring of mental health.

SUMMARY:

Depression is a common disorder, estimated to affect approximately 350 million people worldwide. Depression is costly and one of the main sources of personal suffering and despite available effective

treatments depression unfortunately remains often untreated or patients do not respond to conventional treatment approaches. Depression affects people in all communities across the world and is the leading cause of disability worldwide in terms of total years lost. Research has shown that depression is a major factor in attempted/completed suicide. Generalized anxiety disorder (GAD) affects approximately 5.7% of the population and is the most common form of anxiety disorder found in the primary care setting. If left untreated, GAD is associated with increased societal costs and can substantially reduce the quality of life of the individual patient. There are different conventional approaches in treatment of mood and anxiety disorders, mainly pharmacological treatment and psychotherapy. Although patients benefit from these methods, there are many people who are sufficiently responding to these treatments. In this session the speakers will talk about different emerging treatments and approaches for mood and anxiety disorders. Dr. Y Knyahnytska will talk about the effectiveness of Repetitive Transcranial Magnetic Stimulation (rTMS) in depression. She will provide an overview of current evidence for rTMS and discuss potential response predictors for rTMS. Dr. N Alavi will discuss challenges in receiving in-person psychotherapy and will present evidence supporting a shift to online psychotherapy and will specifically talk about online cognitive behavioral therapy for depression and anxiety. Dr. A Munshi will discuss the importance of assessing and treating depression and anxiety from a culture and equity lens, and how this can impact not only treatment outcomes but client satisfaction with care and access to care. This talk will include an overview of current evidence to facilitate culturally competent assessment, formulation, and treatment of patients presenting from diverse backgrounds. I will be discussed how issues related to culture and equity can impact access to care, and some steps to improve barriers. Dr. I Husain will provide an update on current evidence for the use of anti-inflammatory treatments in mood disorders with a focus on results from recent clinical trials of minocycline and celecoxib in major depressive disorder and bipolar disorder.

Ethical and Legal Issues in the Management of High Risk Patients in College

Chair: Ludmila B. De Faria, M.D.

Presenters: Andres Julio Pumariaga, M.D., Jonathan Weiss, M.D., Lillian Mezey, M.D., Steven J. Siegel, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. To understand legal, ethical and administrative issues involved in risk management of high risk patients in college; 2) 2.

To identify the need for higher level specialty care for students with severe mental illness; 3) 3. To address financial burden of treatment for students while on leave versus enrolled students; 4) 4. To understand the role of systemic health disparities in high risk minority population students; and 5) 5. To understand the need to create institutional policies that safeguard the rights of both patients and the college community

SUMMARY:

College counseling centers and health services have witnessed a steady increase in numbers of students seeking psychological counseling and psychiatric treatment, with an even bigger increase in the number of students with severe mental illness. This reflects an improvement in the awareness of and screening for mental health needs in children and adolescents as well as changes in practice of Child and Adolescent Psychiatry. Thanks to effective psychiatric treatments and academic accommodations, more young adults with mental health symptoms now advance to secondary education, with college campus populations reflecting the national mental health trends of America's young adults. Counseling center use has increased at five to seven times the average rate of institutional growth over the last 5 years, with 1 out of 2 clients having had counseling before, 1 out of 3 having taken a psychiatric medication and roughly 1 in 10 been psychiatrically hospitalized. They report an increase in self-harm and suicidal behavior, as well as high profile violent incidents. These trends have challenged traditional models of mental health service delivery on campuses and raised concerns about risk management. Institutions responded by

widening the scope of services provided. Psychiatric services on campus grew from 54.5% to 64.1%, with only about half of those being fully integrated with counseling centers, despite about 26.5% of students seen being on psychotropic medication. Although most students coming to counseling centers report depression and anxiety, less common concerns (eating disorders/psychosis/suicidality) are becoming more prevalent. Institutions improved their ability to identify students at risk and refer them to mental health services, shifting risk assessment to the provider. Some schools rely on community services, creating multiple transition of care points, with poor or no coordination. Other institutions have opted to retain high risk patients. In these institutions, administrators may be heavily involved in dictating care and outcomes, either to prevent media scrutiny or to maintain academic standards. Providers now need to balance advocacy for their patients with facilitating communication among those on and off campus and protecting students' privacy and confidentiality. Federal agencies rules, FERPA and HIPAA, state and local laws, as well as various professional ethical guidelines can be difficult to understand and navigate. In addition, costs of care often exceed students' health fee and result in limited options, especially for minority and underserved populations, whose needs are often unmet until they arrive in college. This session will bring together experts in the field for a panel discussion on the subject, highlighting current ethical and legal issues associated with it, and the need to establish solid policies addressing risk management, treatment and re-entry post-hospitalization or leave of absence for high risk students.

Feedback CPR: Breathing New Life Into Evaluations of Medical Students and Trainees

Chair: Barbara Wilson, M.D.

Presenter: Samuel A. McCord, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understanding the common fears that physicians have prior to giving feedback; 2) Recognize the most common trainee responses to feedback; 3) Practice recognizing and remedying these responses in a role-play format; and 4) Utilize

take-home strategies for productive feedback discussions with medical students and trainees

SUMMARY:

Many physicians do not like to give feedback. They are concerned that their words may lead to hurt feelings or they may not know how to approach a personality/professionalism issue. Many trainees are not accustomed to receiving informative feedback. Receiving news that there is room for improvement in their performance can lead to a range of emotions for a trainee: from shock, sadness, denial and agreement to a complete assault on who he or she is as a person. The end result is that physicians do not provide enough helpful feedback for trainees to be successful and trainees do not apply the pieces of useful feedback they receive in order to meet or exceed expectations. This session will address the art and practice of feedback by highlighting common pre-feedback fears, trainee responses to feedback, and post-feedback follow-up. Attendees will observe and participate in role-playing scenarios for feedback be provided with some strategies to develop a more uniform delivery of feedback to trainees.

From Arrest to Recovery: Reviewing the Continuum of Correctional Behavioral Health and Diversion in San Francisco

Chair: Loren Roth, M.D.

Presenters: Jacob Michael Izenberg, Fumi Mitsuishi, M.D., Carrie Melissa Cunningham, M.D., Tanya Mera

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current role of criminal justice settings in the care of the seriously and persistently mentally ill; 2) Be able to describe a model for comprehensive psychiatric care for individuals in a county jail and a program for diversion to community-based care.; and 3) Identify challenges and opportunities associated with leveraging the criminal justice system to expand access to psychiatric care

SUMMARY:

The largest provider of mental health services in the United States is a jail. So is the second largest. And the third (1). An array of social, legal, and economic forces—including not only cuts to systems of

psychiatric care, but also broader socioeconomic inequality, the war on drugs, and the dismantling of the social safety net to name a few (2; 3)—have combined to create a situation in which increasing numbers of those with psychiatric conditions find themselves behind bars. The numbers are indeed staggering: by some estimates, around 50% of the incarcerated population has a significant mental illness; in jails the number may be higher than two thirds (4). Traditionally, mental health care in correctional settings, mandated though it may be, has been inconsistent at best and nonexistent at worst, while jails and prisons themselves are not typically environments designed for or conducive to emotional wellbeing. Yet, in recognition of the increasing importance of psychiatric care in correctional settings, some systems have made efforts to bolster their treatment of mental illness. In parallel, innovations have arisen to leverage criminal justice proceedings to divert inmates from jails into community-based mental health treatment (5). San Francisco (which, unlike most jurisdictions, is both city and county in one) has been at the forefront of implementing both a comprehensive correctional behavioral health system (herein referred to as Jail Behavioral Health Services, or JBHS) and a mental health diversion approach, the behavioral health court (BHC), as well as additional services for individuals on probation. The speakers in this session represent the spectrum of correctional mental health care for adults in San Francisco, including psychiatric evaluation and management, comprehensive re-entry, behavioral health court, and specialized community services. Following an imagined patient living on the streets of San Francisco with severe, untreated mental illness, our proposed session will trace the continuum of care, from arrest and intake screening through jail-based behavioral health programs, psychiatric evaluation, workup, and treatment, specialized psychiatric housing, BHC, and ultimately to community-based care and case management. In doing so, we will discuss how a correctional system serve as first point of contact for a comprehensive intervention aimed at recovery. Our presenters will detail specific program innovations, successes, challenges, areas for continuing development, and knowledge gaps. Along with a series of presentations, our session will include ample time for interactive discussion of our

approach, alternatives, and broader issues related to care of jail-based systems of care.

From Stonewall to Tomorrow: Drawing on LGBTQ+ History to Improve Your Practice

Chair: James Koved, M.D.

Presenters: Caitlin Rippey, M.D., Ph.D., Jesse Markman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List key moments in the modern LGBTQ+ rights movement; 2) Describe the importance of mental health providers in creating inclusive, comfortable spaces in medical settings; and 3) Report an increased level of comfort working with patients who identify as transgender and gender diverse

SUMMARY:

Individuals who identify as sexual minorities (lesbian, gay, bisexual, transgender, queer, and/or other sexual minorities) are seen to have higher rates of primary mental illnesses than the general population, as well as higher rates of comorbid personality and substance use disorders (1). Yet many LGBTQ+ patients have concerns about accessing health care. Historically, major medical and mental health institutions have pathologized homosexuality, promoting stigma and shame. Today there remain significant gaps in provider and institutional knowledge and attitudes on this topic, even amongst well-meaning individuals, which contributes to a significant barrier to care for this patient population (2). This session is designed for participants of all identities who want to strengthen their cultural competency skills. Participants will engage with the history of psychiatry and the modern LGBTQ+ movement, then use this foundation to understand today's challenges. We will guide discussions about working collaboratively with patients who identify as transgender and gender diverse, creating inclusive spaces in medical settings, and address lack of provider comfort and uncertainty about these topics. Participants will develop a personal action plan for enhancing their clinical care with LGBTQ+ patients.

Frontiers in Rural Mental Health: The Intersection of Place and Regional Culture in the Cultural Competence Landscape

Chairs: Toni Love Johnson, M.D., Vikas Gupta, M.D., M.P.H.

Presenters: Brandon Kyle, Irma Corral

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the critical components of rural identity and the concept of rural as one of many intersectional identities; 2) Identify differences in rural and urban health, particularly regarding mental health; 3) Describe how rural identity intersects with other diverse identities including race/ethnicity, sexual orientation, and gender identity to impact mental health; and 4) Understand strategies for educating trainees and providers to increase competence in rural mental health care delivery

SUMMARY:

This session is intended for providers who may be new to working in rural settings, for training directors looking for ideas regarding how to introduce new learners to the complexity of rural care delivery, or for professionals at any level who want to better understand how to work in rural settings. People living in rural and urban communities differ in their health outcomes, and several factors account for rural and urban differences in physical and mental health. [1,2,3,4,5,6] Compared to people living in urban environments, people living in rural areas lack resources, have access to fewer providers, are less likely to have adequate health insurance, have less mental health awareness, and experience increased stigma towards mental health. [7,8,9,10] Despite these important health disparities, education in cultural competence often leaves out rural identity. In this session, after elaborating on rural vs urban health inequities, we will provide some guidelines for incorporating rurality when using an intersectional identity framework. Intersectionality theory challenges us to consider social determinants of health not in terms of single factors (e.g., gender or SES) but in terms of multiple, interacting factors. [11] Within this framework, social disadvantage results from a constellation of interrelated and

intersecting social roles; this view is referred to as the 'double' or 'triple' jeopardy hypothesis. [12] Rurality, as one of many intersectional identities, significantly impacts mental health care and delivery. Researchers have proposed that, compared to other geographical regions, rural populations express a unique set of attitudes, beliefs and behaviors: self-reliance, conservatism, individualism, fatalism, distrust of outsiders, strong family orientation and strong work orientation. [13] Rural residence also appears to influence health of sexual minorities, who already are at increased risk for a variety of health disparities. [14] Additionally, the rural American South, in particular, is home to the vast majority of African Americans who live in rural areas. These families are among the most vulnerable people due to historical and systemic factors. They have experienced multi-generational traumas, oppression, segregation, discrimination and poverty, all of which have an impact on overall health and health help-seeking behaviors.[13] The strategies to increase competence in rural mental health delivery include reducing stigma of mental illness by education, improving number of providers and improving access and availability of mental health services.[15] These strategies for competence in working with rural patients, as well as ways to incorporate them with patients' others intersecting identities, will be presented during this session, in the service of increasing providers' overall cultural competence.

Gathering the "Rebellious": The Development of a Trainee-Led Conference Examining the Intersection of Mental Health and Social Justice

Chair: Nientara Anderson

Presenters: Flavia Alecia Ruth De Souza, M.D., M.H.S., Kunmi Sobowale, M.D., Marco Ramos, M.D., Myra Mathis

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss structural and logistical challenges of creating a multi-disciplinary conference with a focus on social justice.; 2) Identify obstacles to creating dialogue about social justice in their own institution.; 3) Develop strategies for overcoming these obstacles to creating dialogue about social justice within their own institution.; 4) Identify the vulnerabilities of their own institutional

position (such as being trainees, minority physicians, etc) and how to navigate these vulnerabilities when organizing around social justice.; and 5) Apply the concept of “Rebellion” as a framework for organizing to advance social justice in psychiatry while being part of an academic medical institution.

SUMMARY:

How do we understand ‘social justice’ within psychiatry? While mental health professionals have long been engaged in social causes, from working with marginalized populations to the global mental health and recovery movements, we must also grapple with our participation in individual and structural oppression, such as Guantanamo interrogations, racial disparities in psychiatric diagnosis, and the pathologizing of LGBTQ communities. Given our complicated past and present, how can psychiatrists be agents of social change? Inspired by the Rebellious Lawyering (RebLaw) conference at Yale, Rebellious Psychiatry (RebPsych) has wrestled with these questions over the last two years. In this workshop, we will share our experiences developing the Rebellious Psychiatry Conference at Yale. We will discuss the lessons learned, and the obstacles faced while organizing a conference on social justice and psychiatry. Specifically, we will discuss the discomfort of situating a conference about social justice at an academic medical center, which has a fraught relationship with its surrounding community. We will also explore the multiple, and sometimes conflicting, social justice agendas that emerged at these conferences – ranging from criminal justice reform and mental health, refugee mental health, and legislative advocacy, to poverty and mental health, the recovery movement, and racial justice in psychiatry. Why are certain visions of justice excluded—and even censored—in academic medicine, while others are celebrated? We firmly believe in gathering these different perspectives on justice by bringing together a wide range of presenters and attendees at RebPsych. This included not just health practitioners, but also activists, artists, community organizers, patients, scholars, students, and writers. However, organizing a conference that convenes so many stakeholders, representing different disciplines and perspectives, presents its own difficulties. The workshop will

address the complexities of organizing a conference targeting all these groups; many of who speak different languages, represent different political agendas, have uneven power relationships, and may even have a history of opposition to psychiatry and to one another. Finally, we will explore the promise of “rebelliousness” as a framework for advancing social justice in psychiatry broadly. In breakout groups, we will workshop the obstacles to, and resources for, organizing around rebellion and justice at your own institutions. We will explore the complexities of organizing as trainees under the banner of “Rebellion” including navigating relationships with faculty allies, balancing competing responsibilities, and working with scant time and limited resources.

Ghosts in the Office: Historical and Contemporary Structural Considerations in Black Mental Health

Chair: Sarah Yvonne Vinson, M.D.

Presenter: Ledro Justice, M.D.

Discussant: Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the historical and present-day context of structural racism and its role in social determinants of mental health; 2) Describe possible implications of individualized, internalized and structural racism of mental illness in blacks; 3) Identify actions that clinicians can take, both within clinical roles and as members of their professional communities, to address the mental health ramifications of structural racism; 4) Describe the contributions of pivotal thought leaders in understanding structural racism from the fields of history and sociology such as Dr. John Hope Franklin and Dr. Charles Pinderhughes; and 5) Articulate possible strategies to promote inclusion on both the societal and individual levels

SUMMARY:

The history of formerly enslaved black people in the United States and their descendants has a unique place in the United States. While slavery is often thought of as a thing of the past, the institution was a far-reaching financial cornerstone and slaveholding states had an outsized influence on the nation’s formative years. The trauma of slavery, its social

stratifications, and the rationalizations for its existence, have been perpetuated by other social assaults such as Jim Crow, domestic terrorism through organizations such as the Klu Klux Klan, and discriminatory housing policies from the federal government. In understanding the entrenched, pervasive nature of these issues, it is imperative to draw upon the contributions of historians and sociologists. The ongoing impact of these events contributes to present day problems such as black disproportionate exposure to poor academic opportunities, mass incarceration, and exposure to violent communities. Additionally, the rationale for the justification of slavery, the inferiority of blacks, is one that remains prevalent in American messaging, whether it be through the educational system, from politicians or through media representations. In this presentation, a structural competency approach will be applied to explore the ongoing impacts of slavery and institutional racism, the ways in which these issues can impact patients and clinicians and the psychiatrists role and responsibility in not only being aware of but combatting these issues. The session chair and didactic presenter is an early career psychiatrist and faculty at a history black medical school. The discussants are Dr. Ledro Justice, a black male psychiatrist with a perspective informed by 45 years of psychiatric practice, and Dr. Altha Stewart, the first black president of the American Psychiatric Association. Each of the discussants will comment on personal experiences pertaining to structural, overt and implicit racism. Additionally, they will share about how this has informed their clinical practice and advocacy work.

Health Care Systems, Malpractice Insurers, and Aging Physicians: Emerging Age-Based Assessment Practices Part 1

Chair: James Michael Ellison, M.D., M.P.H.

Presenters: Kelly Garrett, Hayes Whiteside, Ann Weinacker, Ross Campbell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how age-associated changes affect physician performance; 2) Learn about developing age-based assessment practices in US healthcare systems; 3) Increase awareness of how age impacts on malpractice insurance

underwriting; and 4) Appreciate the legal and ethical implications of age-based physician assessments

SUMMARY:

Did you know that nearly a quarter of US physicians and over a third of male US physicians are at least 65 years old? One inevitable consequence of the aging of our physician work force is increased attention to the effects that cognitive and physical aging can have on professional performance. Age in itself is not a detractor, but age is often associated with changes in function that undermine a physician's ability to sustain the pace, new learning, and technological advances that characterize modern medical practice. Several foreign countries and an estimated 10 per cent of US health care institutions have already adopted "aging practitioner policies" to address this concern. No definitive approach has emerged yet, and policies vary greatly from institution to institution. Malpractice insurers, furthermore, are incorporating age-based physician interviews into underwriting and policy renewal practices. Growing awareness among physicians regarding age-based assessment policies is stimulating curiosity and discussion about their ethical and legal implications. In this symposium, we will hear about the changing demographics of the US physician work force and the evidence linking aging with performance issues. We will hear about age-based assessment policies already implemented in other countries and those that are being adopted by US health care systems. We will learn how the malpractice insurance industry views aging of physicians, and we will learn about the ethical and legal considerations relevant to age-based policies. A panel discussion will field questions and provide an opportunity for attendees to voice their opinions and concerns.

Health Care Systems, Malpractice Insurers, and Aging Physicians: Emerging Age-Based Assessment Practices Part 2

Chair: James Michael Ellison, M.D., M.P.H.

Presenters: Kelly Garrett, Hayes Whiteside, Ross Campbell

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how age-associated

changes affect physician performance; 2) Learn about developing age-based assessment practices in US healthcare systems; 3) Increase awareness of how age impacts on malpractice insurance underwriting; and 4) Appreciate the legal and ethical implications of age-based physician assessments

SUMMARY:

Did you know that nearly a quarter of US physicians and over a third of male US physicians are at least 65 years old? One inevitable consequence of the aging of our physician work force is increased attention to the effects that cognitive and physical aging can have on professional performance. Age in itself is not a detractor, but age is often associated with changes in function that undermine a physician's ability to sustain the pace, new learning, and technological advances that characterize modern medical practice. Several foreign countries and an estimated 10 per cent of US health care institutions have already adopted "aging practitioner policies" to address this concern. No definitive approach has emerged yet, and policies vary greatly from institution to institution. Malpractice insurers, furthermore, are incorporating age-based physician interviews into underwriting and policy renewal practices. Growing awareness among physicians regarding age-based assessment policies is stimulating curiosity and discussion about their ethical and legal implications. In this symposium, we will hear about the changing demographics of the US physician work force and the evidence linking aging with performance issues. We will hear about age-based assessment policies already implemented in other countries and those that are being adopted by US health care systems. We will learn how the malpractice insurance industry views aging of physicians, and we will learn about the ethical and legal considerations relevant to age-based policies. A panel discussion will field questions and provide an opportunity for attendees to voice their opinions and concerns.

History of HIV Psychiatry: Psychiatric Response to the Epidemic

Chairs: Mary Ann Adler Cohen, M.D., Marshall Forstein, M.D.

Presenters: Francine Cournos, M.D., Karl Goodkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the impact both mental health and HIV stigma on the history and course of the HIV pandemic; 2) Integrate three HIV prevention measures into their day to day care of patients; 3) Understand the role of psychiatrists in the care of persons infected with and affected by HIV; and 4) Describe the evolution of HIV-associated neurocognitive disorders

SUMMARY:

In 1981, previously healthy young men and women were being admitted with pneumonia and severe respiratory distress to the intensive care units of medical centers. They were mysteriously dying of respiratory failure. The cause was found to be *Pneumocystis carinii* pneumonia (PCP), one of the first opportunistic diseases that heralded the HIV epidemic. Remarkably, in less than four decades, competent HIV medical care and research energized by the activism and advocacy of the gay community, transformed AIDS from a rapidly fatal illness of unknown cause into a manageable chronic illness in persons who can adhere and respond to HIV care and antiretrovirals. But the HIV pandemic is still with us. In the United States 1.1 million people are living with HIV and 37,600 are newly infected each year. Worldwide, 36.7 million people are living with HIV, 5000 are newly infected daily, and 17 million orphans have been left behind by AIDS. HIV psychiatry is defined as the subspecialty of consultation-liaison psychiatry that focuses on prevention, care and treatment of HIV and AIDS, including psychiatric aspects of risk behaviors; psychiatric manifestations of HIV and its stigma; psychological consequences of HIV and its multimorbidities; impact on persons who are infected and affected by HIV; and the need for a collaborative biopsychosociocultural approach to prevention, care, and adherence. This presentation traces the history of HIV psychiatry. Beginning with an overview of the HIV epidemic we describe how denial and resistance to addressing HIV infection early on was a precipitant for activism and work with the APA to view AIDS as a neuropsychiatric illness with enormous psychosocial implications that led to the development of HIV curricula and training

programs for medical students and psychiatrists; the bidirectional aspects of severe mental illness and HIV infection; the evolution of HIV-associated neurocognitive disorders and addictive disorders; the syndemics of trauma, addictive disorders, PTSD, and other psychiatric disorders that perpetuate the HIV epidemic; the role of HIV psychiatrists in prevention of mental health stigma and AIDSism and prevention of HIV transmission with treatment as prevention, PrEP, and PEP. Although AIDS is an entirely preventable infectious illness, HIV transmission continues throughout the world, fueled by the stigma of mental illness and of HIV, as well as by discrimination and criminalization. A biopsychosociocultural approach to sexual health and mental health and diminution of stigma is essential to both HIV prevention and HIV care and can have a significant impact on HIV-related morbidity and mortality. In this presentation we invite participants to share how HIV has impacted their practice of psychiatry and the disproportionate impact HIV has had on people of color, people who are LGBT, and immigrants, people who are homeless and marginally housed, and people with substance use disorders and other mental illnesses.

HIV Stigma and Discrimination: Impact on Patients, Orphans, Families, and Prevention

Chair: Mary Ann Adler Cohen, M.D.

Presenters: Luis Filipe Gomes Pereira, M.D., Jordi Blanch, M.D., Ph.D., Getrude Makurumidze

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess the impact of stigma and discrimination on patients and their community; 2) Assess the impact of stigma on AIDS orphans; and 3) Assess for behaviors that lead to transmission of HIV and help patients ameliorate or change behaviors

SUMMARY:

In 1981 and in the initial phase of the pandemic, the cause of the new illness had not been identified and the fact that AIDS was associated with infection, severe and inexorable devastation of the immune system, severe and profound wasting and a skeletal appearance, and inevitable death in young and previously healthy individuals contributed to the development of both fear and stigma that are still

present nowadays, despite the dramatic advances in the care and prognosis for persons living with HIV since the onset of the pandemic. Stigma prevents persons from getting HIV tested, prevents orphans from understanding why they lost their parents, and prevents persons with HIV from accessing care and obtaining effective treatment. All these factors have a real implication in the incidence and transmissibility of HIV. A biopsychosocial approach and the collaborative care for persons with HIV can help decrease AIDSism and discrimination. Targeted interventions are needed at the health care level to promote de-stigmatization of health providers. We will use an interactive approach to stigma with audience participation. Consultation-liaison psychiatrists are in a unique position to provide compassionate care, teach communication skills and coordinate the care of persons with HIV/AIDS. This symposium will provide participants with strategies for delivering compassionate care to patients and communities affected by HIV. Participants will gain an understanding of the roles of stigma and discrimination in hindering both the care of persons living with HIV and also in preventing HIV transmission.

Homeless Community Outreach: An Essential and Disruptive Practice

Chair: Craig P. Kaufmann, M.D.

Presenters: Megan Smith, Meredith Adamo, Sarah Kler, Sara Heejung Park

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the unique role of homeless outreach as a vital part of the continuum of care; 2) Become familiar with one model of nontraditional community focused education for interdisciplinary helping professions students, including psychiatry residents; 3) Explore what it means to be an activist-teacher and activist-clinician. What does this mean philosophically and practically? How does this expand on our traditional professional identities?; 4) Review the disruptive and motivating power of community work in sparking innovative programs; and 5) Critically consider the ethical and practical challenges that this work presents and how we can support each other, students, and

institutional and academic partners in navigating them

SUMMARY:

This past spring, a medical student on her internal medicine rotation was working with a patient experiencing homelessness who eloped from the hospital. The patient was still in dire medical need. The student, familiar with homeless outreach work, diligently reached out to the patient in the community and was able to connect her with follow-up care. This successful intervention, while commonplace and safe to any outreach worker, was viewed by the academic medical service as unsafe and inappropriate practice. The scenario above, and many others, point to the need for an update and expansion of the clinician role to include practices that, while logical and effective, are at best viewed as innovative and at worst, inappropriate and dangerous. The homeless community suffers from premature mortality due in part to high rates of untreated substance use and mental health conditions. It is estimated that of the approximately 550,000 individuals who experience homelessness in the US annually, 20-25% struggle with mental illness (1). Among those experiencing street homelessness, this number is significantly higher. This population is often entirely excluded from care, and when they are seen, often receive traumatizing care. Just as the status quo is not working for those in need of psychiatric services, it also stifles students and practitioners wishing to work with this population. Studies have demonstrated that idealism and desire to work with vulnerable populations drop as students move through their medical education (2). The reasons for this are multi-factorial, and include professional socialization, increased attention to prestige/compensation, and lack of opportunities for longitudinal and supervisor supported engagement with marginalized groups (3,2,4). These drivers of movement away from this practice share a common core: there are not enough opportunities to meaningfully engage with these patients or with the systemic forces that contribute to their oppression (and thereby, poor health outcomes). There are ways to change this. Five years ago, a group of medical students joined outreach workers in Providence, RI, leading to the evolution of a strong community-academic connection within the local

homeless community. Several novel educational programs across disciplines formed, including students regularly joining on outreach, three medical school and social work electives, and many adjunct student-run initiatives. These have evolved as founding students have advanced in their education and new students have joined. This context and experience will frame an interactive small group exercise about how we can bring this model to scale. Watts et al (2003) describes a model of integrating social justice into mental health practice and the concept of the activist-scholar, or, adapted, the "activist-clinician." It is our hope that this may serve as a starting point for ongoing collaborative communication among participants and within the APA.

How Do I Prescribe Exercise for Depression?

Chairs: Rohul Amin, M.D., Adam Lee Hunzeker, M.D.

Presenters: Rachel Snell, Michelle Samson Maust, M.D., Courtney Elizabeth Kandler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe evidence for the use of exercise augmentation in depressive disorders; 2) Demonstrate prescribing goal-based exercise utilizing Exercise Pocket Card; 3) Demonstrate American College of Sports Medicine's (ACSM) exercise preparticipation health screening process using the provided Exercise; and 4) Demonstrate follow-up assessment, adherence, and motivational enhancement in a patient with depression who is prescribed exercise

SUMMARY:

Depression is a common presentation in all psychiatric practices. Various modalities are available to the psychiatrists including first-line medications and psychotherapies. Unfortunately, only 40% of patients respond to the first intervention. Patients with depression require subsequent changes and/or augmentations to treatment. The addition of medications put patients at risk for poly-pharmacy and associated risks of side-effects. Exercise is a potential augmentation strategy among appropriate patient populations. According to leading clinical guidelines, offering exercise as adjunct treatment is recommended to

patients with depression. There is ample evidence that shows the positive effects of exercise in depressed patients. Along with antidepressants and lithium, exercise is known to increase brain-derived neurotrophic factor (BDNF), a factor associated with treatment response in patients with depression. Exercise and physical activity also improves other protective factors associated with depression including reduction in cortisol, increased relaxation, and enhanced self-esteem. Despite these positive findings from controlled trials, many psychiatry residents and practicing psychiatrists do not have the practical knowledge and skills to prescribe exercise and physical activity to their patients. We aim to help close this knowledge and skill gap by providing the learners the current evidence and guidelines for the use of exercise and physical activity in depressive disorders in this highly interactive workshop. Following enhancing their knowledge, we plan to have the learners apply this knowledge in small groups using clinical vignettes. We will also discuss motivational interviewing techniques to enhance adherence and address relative contraindications to exercise and physical activity. In order to operationalize the procedure of prescribing exercise in busy clinical settings, learners will be provided pocket cards and other deliverables that can be taken back to their clinics and residency programs. The pocket card provides quick steps on assessing motivation level, quick motivational interviewing, rapid medical screening and appropriateness for exercise, and blank exercise prescription form. Our team includes psychiatrists, physical therapist and primary care physicians.

How We Live Now: The State of LGBTQ Mental Health in the Current Political Times

Chair: Amir K. Ahuja, M.D.

Presenters: Howard Charles Rubin, M.D., Mark Joseph Messih, M.D., M.Sc., Ariel Shidlo

Discussant: Dinesh Bhugra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) By the end of this symposium, attendees will be able to describe the current mental health challenges facing LGBTQ people.; 2) By the end of this symposium, attendees will be able to describe the negative impact of the current political

climate on LGBTQ mental health.; 3) By the end of this symposium, attendees will be able to explain specific challenge areas, such as Transgender involvement in the Military, Conversion Therapy, and Asylum Cases.; 4) By the end of this symposium, attendees will be able to describe specific ways they can assist in advocating for their LGBTQ patients in general.; and 5) By the end of this symposium, attendees will be able to institute specific changes in their institutions and individual practices to overcome these aforementioned challenges for LGBTQ patients.

SUMMARY:

It is well studied that there are disparities for the LGBTQ community in terms of mental health disorder prevalence and outcomes. The current political climate has led to an increase in the anxiety and depression of this community. This has been shown in previous studies that illuminate the phenomenon, as LGBTQ people do have worse outcomes in hostile political environments. In today's time, there are many challenges for people in this community. Some specific ones we are focusing on in this presentation are things that affect many of our patients, and also have a clear political component. Namely, these issues are the following: workplace protections and housing discrimination for LGBTQ people, open Transgender service in the military, conversion therapy, and the issue of Asylum cases for LGBTQ refugees. In each of these cases, there are political forces that are currently on the side of curtailing rights for LGBTQ people, and that is having a real effect for patients in this community. To start with, Howard Rubin will discuss the importance of protections against discrimination in housing and employment. These measures are being threatened across the country, and they are crucial to the mental health of many LGBTQ patients. Dr Rubin will speak about this issue and what Psychiatrists can do as advocates for our patients. In addition, Dr Rubin will provide an overview of the whole current situation in regards to LGBTQ rights. Next, Dr Mark Messih will discuss a case presentation with a patient who is a survivor of Conversion Therapy. This is a very hot topic these days, as legislation around the country is pending to ban this practice, but many current political leaders are in favor of this damaging practice and are

working to keep this legal. Dr Messih will discuss how this impacts all of our patients, and what we as practitioners can do about this. Third, Dr Amir Ahuja will discuss the policy of open Transgender service in the US Military. He will provide an overview of the ban that was overturned in 2016, and that is now under threat of being re-instated by the current administration. He will review the research and show how this is an issue of which we should all be aware. He will discuss how it impacts our patients and their mental health. Our final presentation is from Dr Ariel Shidlo, who will discuss Asylum applications for refugees. The United States frequently gets LGBTQ refugees from parts of the world where being in this community is illegal and people are subject to punishment, harrasment, and even death. Dr Shidlo will discuss the process of helping these patients with Asylum applications, and what impact the current administration's anti-immigrant stance has had on LGBTQ refugees. Following, we will have a discussion with Dr Dinesh Bhugra, the President of the WPA, who will give an international perspective on this issue. Afterwards, there will be an audience Q & A.

If You Build It They Will Come: Enticing Medical Students to Enter Psychiatry

Chair: Randon Scott Welton, M.D.

Presenters: Allison E. Cowan, M.D., Bethany Harper, M.D., Ryan C. Mast, D.O., Rachael Mary Ferrari, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss trends in medical students selecting psychiatry training; 2) Identify opportunities to influence medical students to enter psychiatry; 3) Appraise the value of varying strategies to entice medical students to enter psychiatry; and 4) Create a multi-dimensional approach to increasing medical student interest in psychiatry

SUMMARY:

There is a national shortage of psychiatrists even though the profession offers a stimulating career, reasonable remuneration, and a broad variety of work and life style options. Despite this need and these benefits, recruiting the ablest medical students into psychiatry remains a challenge. The

numbers have been rising, but still only about 5% of allopathic medical school graduates will enter psychiatry. Although most psychiatry residencies have little problem filling their training slots, psychiatry residencies should position themselves to attract the best and brightest graduates. The literature indicates that the timing and characteristics of medical students' exposure to psychiatry will impact their career decision. This workshop will highlight the efforts of one medical school which regularly exceeds the national rate of graduates going into psychiatry by 50%. This success stems from a multi-pronged strategy to excite medical students about psychiatry. The Department of Psychiatry uses a variety of outreach strategies throughout the medical students' preclinical and clinical years. These efforts involve interactions with both faculty and residents and include the development of 4th year electives which highlight the Department's strengths. Medical students are exposed to the broader world of psychiatry by funded trips to the state psychiatric meeting each year. Interested medical students are also invited to a broad assortment of extracurricular activities ranging from psychiatry interest groups to "movie night" discussions and social gatherings in order to help them further engage with residents and faculty members. Finally, attention is focused on the Department's social media footprint. This is often the picture of psychiatry that is most readily seen. The workshop will have attendees discuss the benefits of the presented strategies and engage the audience in discussions of approaches they have found to be helpful.

Imagining Innovation: Creativity and Convergence in Psychiatry

Chairs: Vineeth John, M.D., M.B.A., Marsal Sanches, M.D., Ph.D.

Presenters: Harris Eyre, M.D., Ph.D., Paulo Marcelo Gondim Sales, M.D., Jaykumar Unni

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Construct working definitions of creativity, innovation and serendipity; 2) Describe the serendipitous discoveries that shaped the field of psychiatry.; 3) Discuss the recent developments in field of neuroscience pertaining to creativity; and 4)

Examine the potential for convergence medicine to innovate both clinical and non-clinical realms in Psychiatry

SUMMARY:

Once considered the product of genius or divine inspiration, creativity — the ability to spot problems and devise smart solutions — is now recognized as a prized and teachable skill. Study of creativity is unfortunately not part of the formal curricular instruction in most academic medical settings. Despite significant breakthroughs in the neuroscience of insight, creativity is often an ignored theme in academic medicine. Creativity moves beyond mere synthesis and evaluation, and is indeed the missing "higher order skill." While traditional academic disciplines continue to be relevant and pertinent, it becomes increasingly important to develop creative strategies to reframe challenges and extrapolate and transform information, and to accept and deal with ambiguity. Creativity positively impacts clinical care, teaching effectiveness, and breakthroughs in research. Serendipity is a critical complement to creative mind set. It represents the ability to capitalize on the potential of accidental encounters. The field of Psychopharmacology owes its origin to many serendipitous discoveries. However, time constraints, limited opportunities for fresh observations and emotional exhaustion seem to have restricted our ability to cultivate serendipity in our chore filled and task oriented lives. Yet, opportunities abound to tap into the narrative creativity of our daily clinical encounters and thus deploy linguistic innovations to create meaningful experiences for both the physician and the patient. Creativity thus becomes a valuable survival tool to navigate the challenges of being a 21st century Psychiatrist. Being creative helps us build sacred spaces for reflection, and unleash the power of metaphor and analogy in our discourses. The workshop proposes to examine our current understanding of innovation and creativity, exploring the neuro-biological underpinnings of creativity, especially the fascinating research paradigms examining insight, default mode network, and top-down control. In addition, we will be introducing a case study detailing the discovery of *Helicobacter pylori* by two relatively unknown Australian physicians, Drs. Robin Warren and Barry Marshall, so

as to highlight the various individual and institutional factors that promote creative breakthroughs including the power of serendipity. We would also present a clinical case which highlights the healing power of narrative creativity in our daily clinical practice. Finally, the symposium explores various insights from the field of convergence sciences in psychiatry resulting in innovations in both clinical and non-clinical realms.

Innovative Approaches to the Opioid Epidemic

Chair: Grace Chang, M.D., M.P.H.

Presenter: Natasha Damaris Perez

Discussant: John A. Renner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss three interventions undertaken by Addiction Psychiatry at the Boston Veterans Healthcare System in response to the rising number of patients with Opioid Use Disorder; 2) Address barriers and limitations experienced in the implementation of these interventions; 3) Evaluate outcomes from these interventions and their impact on our patients with OUD; and 4) Demonstrate how these interventions can increase the provider knowledge and patient access to Medications for Addictions Treatment for Opioid Use Disorder

SUMMARY:

Associated with the escalating number of people struggling with Opioid Use Disorder (OUD), is the increasing number of overdose deaths. In 2016, 42,249 individuals died from opioid related overdoses in the USA; with at least 1,933 in Massachusetts alone. Increasing access to OUD treatment may reduce the morbidity and mortality of OUD, but less than 20% of patients receive appropriate treatment overall. In an effort to improve provider knowledge and patient care, our session will present three novel interventions for the treatment of OUD undertaken by Addiction Psychiatry at the Boston Veterans Health Administration System: 1) the Medications for Addictions Treatment (MAT4OUD) e-consult, 2) Telehealth for Buprenorphine, and 3) the Buprenorphine Resident Clinic. The MAT4OUD e-consult, is an electronic consult evaluation by an addiction service professional, usually our addiction

psychiatry fellows, to facilitate a coordinated transition to MAT for patients from the inpatient detoxification unit to the outpatient setting. This consult has provided the inpatient detox providers with more guidance and confidence initiating MAT for their patients. In addition, the intervention shortens the time for initiation to MAT in crucial moment in a patient's life. Telehealth for Buprenorphine was introduced to provide care to our patients in centers where there are no available buprenorphine providers. This intervention proved helpful in increasing access to care to patients. During our session, we will showcase a different model undertaken to train psychiatrists during their residency years to be more confident and efficient with the treatment of addictions, our Buprenorphine Residency Clinic in the heart of Boston. Our session will discuss how these interventions have increased provider knowledge, availability of buprenorphine/naloxone providers, as well as treatment for opioid use disorder to patients who desperately need it. We will share outcomes data from these three interventions to demonstrate their effectiveness in our patient population. With this session, we hope to increase provider knowledge on available strategies for the management of opioid use disorder. The session will include a question and answer session with a dedicated panel from addiction psychiatrists that have been involved in the process of creating and using these interventions. Our main objective is that other services may be able to incorporate one of these interventions in the management of patients with opioid use disorders to increase access to care and treatment of our patients.

Integrated Diagnosis and Treatment of the Elite Athlete

Chair: Lenard A. Adler, M.D.

Presenters: Brian Hainline, M.D., David Arnold Baron, D.O., Ira David Glick, M.D., Danielle Elissa Kamis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session participants will be able to: understand a broadly based diagnostic scheme around diagnosis of the elite athlete; 2) At the conclusion of this session

participants will be able to: set goals for treatment for treatment of the patient and significant others; 3) At the conclusion of this session participants will be able to: integrate medication and psychotherapeutic interventions; and 4) At the conclusion of this session participants will be able to: understand the state of the art work up of concussion for the elite athlete

SUMMARY:

The evaluation, diagnosis and treatment for the elite athlete presents specific issues to the general and sports psychiatrist. Athletes are at higher risk for a variety of psychiatric conditions including anxiety disorders, major depression, dysthymia, substance use disorders and eating disorders. Furthermore, the treatment of elite athletes is complicated by the omnipresent concerns over mild traumatic brain injury (mTBI) (concussion) and how this may influence the presence and treatment of co-morbid psychiatric conditions and require specific neurologic work-up and follow-up. The high levels of performance required of elite athletes also requires specific monitoring from a cardiovascular standpoint, which is especially true for some psychotropic medications, including stimulant medications, atypical antipsychotic medications, and certain antidepressants and mood stabilizers. The nutritional status of the elite athlete also requires specific consideration, which may overlap and predispose to potential concerns regarding eating disorders. There are also numerous gender specific issues for elite female athletes, which pertain to societal perceptions and mores, mood disorders, eating disorders and tolerability of medications. Finally, as stimulants cannot be taken without a therapeutic use exemption, there are specific issues regarding taking stimulant medications for elite athletes with ADHD. The goal of this submission is to provide a comprehensive guide to the practicing clinician on the issues involved in the evaluation and treatment the elite athlete. The presentations will focus on the evaluation and treatment of the elite athlete regarding: the neurological evaluation and consequences of mTBI, psychiatric consequences of mTBI and resulting co-morbidities, present integrated pharmacologic and psychotherapeutic interventions and issues specific to women athletes.

Integrating Social Determinants of Health Into the Collaborative Care Model

Chair: Eduardo Benjamin Camps-Romero, M.D.

Presenters: Gregory Schneider, Frederick Anderson, Nana Aisha Garba, Maryse Pedoussaut

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the impacts of social determinants on physical and mental health outcomes; 2) Describe an interdisciplinary approach to addressing social determinants integrated with primary and behavioral health care; and 3) Provide examples of how integrating social determinants offers a more holistic collaborative care model

SUMMARY:

Social determinants of health (SDOH) are increasingly being recognized as playing important roles in the well-being of patients and communities. The Florida International University (FIU) Herbert Wertheim College of Medicine (HWCOM) has launched an innovative model of primary and behavioral health integration for underserved communities in Florida's Miami-Dade County. Within our collaborative care model, SDOH are tracked in a population health registry, along with depression and anxiety questionnaires and chronic disease biomarkers. We will aim to describe the theoretical underpinnings of the program and the lessons learned from implementing an upstreamist interpretation of the collaborative care model. HWCOM, in its community-engaged mission, emphasizes social accountability and interprofessional education. Through our flagship service-learning program, the Green Family Foundation Neighborhood Health Education Learning Program (NeighborhoodHELP), students, staff, and providers participate in evidence-based household-centered patient care. Interdisciplinary healthcare teams perform regular home visits with their households. NeighborhoodHELP outreach workers also perform home visits and serve as liaisons with the households and over 155 community organizations. All team members strive to mitigate SDOH risks, as part of their work. Informed by years of engagement in our communities, the NeighborhoodHELP outreach team has developed an innovative Health Risk Profile

(HRP) that longitudinally tracks household members' range of risk and resilience across 10 SDOH domains. These include housing, availability of food, employment, transportation, income, technology, daily activities, healthcare, life skills and education, and legal literacy. Clinically, NeighborhoodHELP also offers a fleet of mobile health clinics that provide primary care, dental care, and mammography screening for uninsured patients. Eligible primary care patients can be referred into the NeighborhoodHELP Collaborative Care Program. In this session, we will demonstrate our SDOH-focused collaborative care program through example patient stories. We aim to show how a more holistic collaborative care approach has informed our care. Through interactive cases, session participants will have the opportunity to identify physical, mental, and social health concerns and explore ways to address these factors individually and collectively. We will present how we measure and attempt to mitigate SDOH alongside medical and behavioral health concerns. Finally, we will provide aggregate data demonstrating positive impacts thus far and areas for improvement.

Intergenerational Transmission of Anxiety: From Genotype to Phenotype to Treatment

Chair: Robyn P. Thom, M.D.

Presenters: David C. Rettew, M.D., Eli Lebowitz, John T. Walkup, M.D.

Discussant: Eva M. Szigethy, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify mechanisms by which anxiety is transmitted biologically and behaviorally across generations; 2) Describe therapeutic strategies to address family system issues in anxious children; and 3) Understand psychopharmacologic principles for treating anxiety disorders across the lifespan

SUMMARY:

Anxiety disorders are among the most common type of psychiatric disorders, with a lifetime prevalence of about 30%. Understanding approaches to early detection and intervention for anxiety is important, as anxiety typically begins during childhood (mean age of onset of 11 years) and can affect normal

social, emotional, and academic development. Furthermore, when untreated, the symptoms of anxiety are often chronic, increase the risk of other psychiatric disorders, and predict a worse prognosis for mood disorders. The transmission of anxiety among families is well recognized, with multiple contributing and mutually interacting mechanisms including learned behaviors, parenting styles, inherited temperament, and genetic influences. Our session will introduce participants to the mechanisms by which anxiety is transmitted among families, both biologically and behaviorally. We will provide information on the role of genetics, epigenetics, and endocrine systems on the biological transmission of anxiety. We will reflect upon how our evolving understanding of transmission of anxiety may contribute to tools for preventing anxiety disorders. A case-based presentation will demonstrate how family systems transmit anxiety behaviorally through family accommodation of child anxiety and highlight therapeutic techniques that can be used to address a family system. Finally, we will discuss pharmacologic principles for the treatment of anxiety across the lifespan.

Involuntary Medication Review Processes: A Closer Look at Judicial, Administrative and Clinical Models

Chair: Lily Arora, M.D.

Presenters: Jagannathan Srinivasaraghavan, M.D., Paul S. Appelbaum, M.D., Steven Jay Schleifer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To provide an understanding of the evolution of pharmacotherapy treatment over objection; 2) To review and clarify three types of processes used to administer medication over objection; 3) To increase understanding of the potential clinical and administrative benefits and challenges of the processes; and 4) To provide insight into procedural factors and patient characteristics that may influence outcomes

SUMMARY:

Treatment over objection for patients in psychiatric facilities remains a challenge nationwide as states seek to balance patient rights and optimal care. Traditional clinical-review policies have largely been replaced by judicial and administrative models. A

large number of states now employ a judicial process to determine whether medication should be administered over objection, some still use clinician-based review and some employ an administrative review panel. Concerns have been raised about potential barriers to optimal patient care in the judicial model due to having non-clinicians make clinically-relevant decisions and, in both judicial and administrative models, as a result of procedural inefficiencies. Two models will be presented and compared, representing judicial and administrative approaches: Illinois and New Jersey. Section 2-107.1 of Illinois Statutes (1991) deals with administration of psychotropic medications and ECT upon application to a court. Reviewing Illinois state data, we found that outcomes with this model varied considerably, a function of the large number and variety of presiding judges, state and defense attorneys, and psychiatrists testifying. For example, during the first five years of the program, the denial rate in Cook County was less than 1% of petitions while 7% were denied in Union County. Our subsequent study of 10 public hospitals (calendar 2000 and 2001) also found considerable variability. The rate of petitions per 1000 cases treated ranged from 2.4-149.6 and denials from 0-41.7%. It should be noted that judicial denial rates do not consider cases withdrawn during the often lengthy interval prior to judicial review. The evolution of the judicial process and factors contributing to variability in outcomes will be discussed in light of more recent data obtained from the state of Illinois. The experience in New Jersey, now following an administrative process (Involuntary Medication Administration Review—IMAR), appears to have been less variable. IMAR utilizes a 3-person review panel including an independent psychiatrist and two non-treating hospital staff. It replaced a 3-step clinical process following a court challenge. Review of the IMAR process for >350 patients at one of the four NJ state hospitals since program inception in 2012 suggests that this more restrictive procedure did not result in substantially decreased applications or increased denials. IMAR is relatively efficient, adding only modest delay to the treatment process, with decisions routinely rendered within one week of application. <5% of applications were denied. 70% of IMARs were resolved within 3 months. Patient characteristics associated with more effective

application of the process will be discussed. The NJ and Illinois findings will be put in the context of the evolution of treatment over objection nationally since the introduction of judicial review in the 1970s.

**It Takes Two: Neurology and Psychiatry
Collaboration for the Assessment and Treatment of
Psychogenic Non-Epileptic Seizures**

Chair: Magdalena Spariosu

Presenter: Fortunato Battaglia

Discussant: Danielle Aroh

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the efficacy of Psychotherapy (CBT, Mindfulness, etc.) for the assessment and treatment of PNES; 2) Practice psychotherapeutic interventions that reveal the somatic manifestations of psychologic distress; and 3) Understand the crucial need for collaboration between neurology and psychiatry teams to effectively treat PNES

SUMMARY:

Psychogenic non-epileptic seizures (PNES) are episodes of movement, sensation, or behaviors that are similar to epileptic seizures but do not have neurologic origin; rather they are somatic manifestations of psychologic distress. Alternate names frequently used for PNES are non-epileptic attack disorder, stress seizures, and functional seizures. Because of the nature of origin of these seizures, antiepileptic drugs – which are often mistakenly prescribed – do not effectively treat PNES and may possibly worsen the symptoms. The present session will address the neurological and psychiatric backgrounds of PNES and collaboration between the two teams for proper assessment and effective treatment. Participants will interact in a Case Discussion with the presenters highlighting the addressed elements with special attention to the psychotherapeutic interventions that were implemented in each case. In this Interactive Case Discussion, participants will be asked to fill in the blanks of clues that point to PNES and be able to share which psychotherapeutic intervention they believe would be most effective for each case. Participants will then learn of the speakers' current projects and research studies on PNES. The speakers

in this session will include one consultation-liaison psychiatrist and one neurologist/neuroscientist-psychiatry research professor who frequently collaborate with each other on psychiatry/neurology cases and discussions between major academic medical centers.

**La Atención Plena: A Pilot Program for Designing
and Implementing a Mindfulness-Based Skills
Group in Spanish for a Low-Income Minority
Population**

Chair: Jacqueline Posada, M.D.

Presenter: Deyadira Baez Sierra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore the usefulness of a mindfulness-based group intervention in a low-income Latino and Spanish-speaking population.; 2) Identify the challenges of adapting Mindfulness-Based Stress Reduction (MBSR) into Spanish for low-income Latino and Spanish-speaking population; 3) Demonstrate how these challenges were addressed in the pilot program and provide examples of how attendees may do the same in their own practice.; 4) Provide examples of course material used in the pilot program, such as the schedule, recruitment materials, meditation scripts, and home practice manual used by pilot program participants; and 5) Review preliminary findings on the impact of the mindfulness intervention on quality of life, mindfulness awareness skills, and stress reduction in participants of the pilot program.

SUMMARY:

Mindfulness Based Stress Reduction (MBSR) is an 8-week, 2.5 hours per week course, based on insight meditation, designed to help patients with chronic illnesses like cancer, pain, depression, and anxiety. MBSR and Mindfulness Based Cognitive Therapy (MBCT) are the predominant methods of mindfulness taught in healthcare settings. Large systematic reviews of the data support the positive, if non-specific, impact of mindfulness interventions on chronic illnesses and mental health outcomes. Mindfulness interventions are not commonly offered to low-income minority populations or in Spanish. Outcomes of 3 studies completed by Beth Roth APRN, FNP-BC suggest MBSR offered in Spanish

improves quality of life, alters perception of chronic illness symptoms, and decreases healthcare utilization in Spanish speaking populations. An intervention like a mindfulness skills group emphasizes self-agency over the label of diagnoses and encourages behavioral and lifestyle changes. Aspects of mindfulness overlap with Hispanic cultures such as prominent spirituality, communion with others, self-sufficiency and optimism, and traditional healing. As a first year APA SAMHSA fellow, I collaborated with Mary's Center, a FQHC in Washington, DC, serving a primarily Latino population, to create a Spanish mindfulness-based program for the population served by an urban community mental health center. To expand the use of mindfulness interventions in community mental health, our group has adapted the traditional 8-week MBSR course to fit the needs and schedule demands of a low-income Spanish speaking population. This session shares lessons learned from our 6 week pilot program. Participants of the session will be guided through the process of creating a mindfulness program that can be adapted for their own community mental health setting. In our pilot program the mindfulness course is taught in Spanish by psychiatrists and therapists. The structure of the mindfulness program was heavily adapted from the curriculum outlined in "A Clinician's Guide to Teaching Mindfulness." The curriculum materials are offered in basic Spanish to guide the home practice, teach about the effects of stress and instruct how to use mindfulness activities to modulate stress response. The traditional 8-week schedule is shortened to 6 weeks of once weekly 90-minute sessions. The formal meditation exercises are shortened and offered in Spanish in 10-20-minute time segments. The session will provide guidance on how to teach other MBSR techniques such as mindful doing and mindful pausing in culturally competent language with examples. The final 20 minutes of the workshop will be dedicated to brainstorming the challenges of adapting mindfulness programs in non-English language or low-income practice settings. We will address challenges such as 1) low literacy levels 2) culturally relevant examples of mindfulness 3) recruitment challenges 4) encouraging adherence to the home practices and group attendance

Let's Talk: How to Engage Female Patients in Family Planning in Outpatient Psychiatric Settings

Chairs: Elena Ortiz-Portillo, M.D., Michelle Elyse Meshman, M.D.

Presenters: Rebecca Kristine Cross, M.D., Christina Guest, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Highlight the importance of discussing family planning in the outpatient psychiatric setting; 2) Introduce practical ways to engage in discussions regarding family planning; 3) Provide an overview of the available options for birth control including barrier, oral contraceptives, birth control patch/implant/shot, vaginal ring, intrauterine device, and tubal ligation/vasectomy; and 4) Review important interactions between certain hormonal birth control options and psychiatric medications

SUMMARY:

Women with mental health issues face unique challenges and risk factors with regard to family planning. In recent years, there has been an increasing emphasis on education for psychiatrists and discussion with patients about the women's needs throughout their reproductive life cycles. In caring for female patients, psychiatrists should inquire about each patient's contraceptive use and family planning goals, and provide counseling about reproductive implications of each patient's specific medication regimen. If necessary, psychiatrists should refer to and collaborate with the patient's primary care physician or gynecologist to establish an appropriate treatment plan. This workshop will include an overview of practical approaches to discussing family planning issues with patients, available contraceptive options, interactions between commonly used psychotropic medications and contraceptives, and potential effects of contraceptives on psychiatric symptoms. Other topics that will be discussed include ethical considerations and sexual history taking. These concepts will be illustrated through case examples and group discussion. This presentation is for psychiatrists, residents, medical students, and any clinician that is interested in women's mental health

issues and its application to the outpatient clinical setting.

Lights, Camera, Action: Using Improvisation and Action to Enhance Social Communication and Perspective Taking in Individuals on the Autistic Spectrum

Chair: Jonathan N. Bass, M.D.

Presenter: Carol Bass, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will be able to identify at least 3 action techniques used to enhance communication in individuals with high functioning Autistic Spectrum Disorder; 2) At the conclusion of this session, participants will be able to understand the role of Improvisation in developing communication skills in individuals with Autistic Spectrum Disorder; and 3) At the conclusion of this session, participants will understand how these techniques enhance the ability to take the perspective of others in individuals, groups, couples, and families

SUMMARY:

Deficits in the capacity to take the perspective of others and effective social communication are central elements in individuals diagnosed with High Functioning Autistic Spectrum Disorder (HFASD). As a function of these problems, members of the ASD community often feel “different” or isolated and are reluctant to take social risks. This is often exacerbated by cognitive delays in formulating responses to social situations leaving the individual feeling at odds with his community or misunderstood within a marriage or the family. The amelioration of these difficulties has been the focus of much clinical work. Historically, these deficits have been addressed using treatments including A.B.A. and C.B.T. While effective, these methods often depend on social scripting or social stories which work well in the clinical setting where it is reinforced by the clinician but is not as readily reinforced in the world at-large as others are not familiar with the scripts and reinforcement schedules. As a result, generalization of effective social communications and the acquisition of the ability to appreciate the “other’s” perspective in

higher level social situations is less likely to occur. Effective social discourse in the non-clinical world requires the capacity to be spontaneous, i.e. to be able to respond effectively to any verbal or social prompt. Individuals who have HFASD often have difficulty being spontaneous in social settings limiting their ability to engage in effective social communications. The question, then, is how does one shape “spontaneity” in this population? We have found that the structures, first described by J. L. Moreno, may be adapted to help individuals with HFASD come to see themselves as others see them i.e. to develop an awareness of the other’s perspective. Having these perceptions affords the individual the opportunity to change their social behaviors. A second finding has been that the “Rules of Improvisation” provide essential elements necessary to develop spontaneity and to enhance social communication. In this session we will demonstrate how Psychodramatic techniques and Improvisation may be used to address these deficits in individuals, groups, couples, and families where one or more individuals have HFASD. Our session will begin with a brief history of the role of action in therapy and the work of J.L. Moreno who developed Psychodrama. We shall then discuss, and invite the audience to participate in, the basic elements used in this action-based modality including Sociometry, role reversal, “doubling”, and Improvisation and how these techniques may be used with individuals, groups, couples and families. Clinical material will be presented illustrating how skills generalize to the “real” world. Finally, with audience participation, we will demonstrate how we use many of these techniques, including Improvisation, in a clinical setting.

Making a Parody of Parity? An Annual Update on the Continuing Struggle for Equitable Mental Health Care Coverage in the U.S.

Chair: Daniel Knoepflmacher, M.D.

Presenters: Susan Gaber Lazar, M.D., Eric Martin Plakun, M.D., Meiram Bendat, J.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the current state of parity implementation and legal efforts to enforce parity laws.; 2) Understand how insurance

companies define the concept of medical necessity; 3) Conduct more effective insurance utilization reviews by using the parity law and knowing associated ethical issues.; and 4) Understand research data supporting appropriate treatments (often denied by insurers) including type, frequency and duration.

SUMMARY:

Since the passage of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, nationwide efforts to guarantee (and circumvent) equitable insurance coverage for mental health care have persisted in earnest. Over the past two years we have seen multiple efforts in Congress to repeal the Affordable Care Act, including those that would remove mental health coverage as an essential benefit. This workshop will provide an update on the continuing struggle for equitable coverage of mental health care. We will present research data on the population of patients who need more care, often of a psychodynamic approach, and how they in particular face routine denial of adequate insurance reimbursement. We will highlight how insurance companies have failed to meet parity standards and review recent developments in Congress and in the courts. After panel presentations we will provide a forum for audience participants to share their own experiences advocating for their patients' coverage and explore together what future changes may come. Our goal is to generate a productive group discussion about parity, a concept that lies at the critical intersection between mental healthcare, politics, business, and the law.

Managing Criminal Confessions

Chair: Tara C. Collins, M.D., M.P.H.

Presenters: Eric Chan, M.D., Mikel Matto, M.D., Jacob Michael Izenberg

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore the legal and ethical concerns surrounding criminal confessions.; 2) Discuss the potential motivations for criminal confessions.; and 3) Explore the limits of confidentiality, Tarasoff duties, and relevant legal issues.

SUMMARY:

This session uses a real-life case example in which a patient presents to a community mental health clinic and reveals a past history of committing serial murder, and current stalking behaviors in the community. As the case is presented, participants will discuss how to best manage similar situations, taking into account the Health Insurance Portability and Accountability Act (HIPAA) and existing statutes and case law regarding privacy, confidentiality, and the risk of misprision (active concealment of a crime). The ethical and legal issues that arise when a psychiatrist weighs protection of the public against the potential rupture of alliance when involving police in a treatment relationship will be detailed, as will the Tarasoff duties that may not be clear in situations with vaguely identified future targets. Finally, this session will also explore literature on the potential motivations for an individual to disclose past commissions of crimes, particularly if such disclosure is actually false.

Men's Mental Health and the Role of Testosterone in Psychiatric Practice

Chair: Justin Bracewell Smith, M.D.

Presenters: Pierre Azzam, Diana M. Robinson, M.D., Ryan P. Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this activity, participants will be able to recognize signs and symptoms of hypogonadism in men.; 2) Participants will be able to apply their understanding of hypogonadism to improve outcomes in men's mental health.; and 3) Participants will be able to weigh the risks and benefits of testosterone replacement for their patients.

SUMMARY:

Our multidisciplinary session will address a vital but often unrepresented topic: the effects of testosterone on men's mental health. In men, a symptomatic decline in serum testosterone (i.e., functional hypogonadism) may trigger a variety of psychiatric symptoms, including low mood, concentration deficits, amotivation, and insomnia. Common medical conditions such as obesity, diabetes, and cardiovascular disease further increase

a man's risk for hypogonadism; the post-partum state, too, has been linked to lower testosterone in new fathers and greater risk for depression. Nevertheless, screening for low testosterone is frequently overlooked in psychiatric evaluation. Given the barriers to psychiatric symptom reporting in men, limited appreciation among clinicians for the role of testosterone can undermine the care that we provide to male patients. For instance, low testosterone may be misdiagnosed as a "primary" psychiatric condition and lead to unnecessary or insufficient treatment. On the other hand, early detection of testosterone deficiency allows for hasty intervention through medication management, lifestyle changes, and referrals for hormonal repletion, ultimately enhancing male quality of life. In this 90 minute session we will begin with an introduction to men's mental health including a discussion of masculine norms and help-seeking behavior. We will proceed to a discussion of the current evidence for the association of low testosterone and depression along with new data this year regarding the prevalence of low testosterone in men who present with depression to psychiatric outpatient clinics. Given the overlap between symptoms of hypogonadism and depression the presented data will be of particular interest to psychiatrists evaluating men in the outpatient setting for depression. Finally our urology colleague Dr. Ryan Smith will review the status of testosterone repletion including a discussion of safety, an update on the 2018 guidelines from the Endocrine Society and American Urological Association, and whether or not psychiatrists should prescribe testosterone.

Mental Health Advocacy in the Community

Chair: Varudhini Reddy, M.D.

Presenters: Varudhini Reddy, M.D., Pranesh Navin Patel, Sherry Ann Nykiel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identifying a gap in healthcare services and/or awareness in the community; 2) Learning the basics of starting an advocacy group; 3) Networking and locating funding for your organization; 4) Utilizing social media to spread your

mission; and 5) Integrating your organization within the community

SUMMARY:

Raising awareness of mental health issues starts in your own community. Advocacy is an underlooked but important channel to address change throughout a variety of social, economic, and political arenas. This change leads to much needed improvements in policy, legislation and treatment access within the community. Our workshop seeks to educate its audience on the basics of advocating at the community level by presenting the development of a nonprofit organization founded by its presenters following medical school. As two recent medical graduates, we noticed the stigma even among health care professionals in addressing opioid addiction in our local community. We saw the need for an organization that would work directly with the medical community to decrease the stigma and better educate medical professionals using evidence based medicine. We founded the Delaware Addiction Project to address this need. In this workshop we will describe the steps and methods we used to accomplish our goals so that others may advocate for their causes as we did. Our lesson plan objectives cover the essentials of forming an advocacy group at the local level, using a combination of didactics and case presentation for a total of 75 minutes in length. We describe the questions and challenges we faced while starting our non-profit and how we worked through them, throughout our presentation. Our workshop will conclude with an interactive open discussion allowing for audience self reflection and feedback.

Message in a Bottle: How Messaging Therapy Extends Reach for Treating PTSD

Chair: Shannon Stirman

Presenters: Thomas Hull, Neil Leibowitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify potential advantages of asynchronous, technologically-mediated psychotherapy delivery systems for addressing improved reach and access to evidence-based mental healthcare; 2) Review the process and outcomes from a pilot study on the effectiveness of

a CPT adaptation for messaging therapy; and 3) Understand the promise and limitations of this form of treatment, and discuss avenues for enhancing its impact while integrating its use into routine clinical care

SUMMARY:

Access to evidence-based care is an ongoing challenge, and information technology-mediated therapies are often sought as a solution for increasing access, reducing stigma, and improving the convenience of receiving treatment. However, providers face at least two challenges when evaluating and utilizing these technologies. The first is the translation of evidence-based protocols onto the technology medium. The second is that some clinical populations are difficult to reach even by internet. These two challenges are common in treating patients with PTSD. Trauma-focused PTSD treatments have been shown to be effective when delivered in person and by telehealth, but have yet to be validated for messaging therapy and barriers to treatment delivery remain in more remote areas, and areas in which individuals do not have access to a computer or internet connection. As a result, the speakers investigated the potential of translating Cognitive Processing Therapy (CPT), a trauma-focused evidence-based treatment for PTSD, onto a phone-based messaging medium. There will be discussion of initial learnings and results from this pilot. The speakers will also discuss treatment as usual (Non-CPT) comparison data from therapists delivering messaging treatment for PTSD. This information will highlight the opportunities, strengths, and challenges of utilizing asynchronous messaging as a therapeutic medium for PTSD. Several cases will also be presented to help ground the conversation in clinical material from messaging sessions.

Millenials Helping Millenials: Exciting the Next Generation of Psychiatrists About College Psychiatry

*Chairs: Amy W. Poon, M.D., Meera Menon, M.D.
Presenters: Mehak Chopra, D.O., Francesco Dandekar, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to describe the increased need for college mental health care and expertise in this field.; 2) Participants will be aware of training opportunities in the field of college mental health.; 3) Participants will understand how to implement programs for college mental health training at their home institutions.; and 4) Participants will learn about a college mental health training curriculum.

SUMMARY:

The need for mental health care among college students has grown exponentially over the last decades—not only are the numbers of students needing care greater, but there is higher acuity as well. 19.9 million students are estimated to attend college this year. Well-publicized problems affecting mental health on campuses include suicide clusters, mass violence, sexual assaults and harassment, and substance use problems resulting in overdoses, intoxications, and deaths. Relatively few consensus guidelines exist on college mental health delivery, medical leave, and legal and privacy issues. Less than 1% of campus counseling centers are run by psychiatrists. As trained medical doctors, psychiatrists are in a position to be strong advocates for improving college mental health delivery. We will discuss this need for specialized training in College Psychiatry, as this expertise is highly valued and sought after, especially when colleges look for guidance to improve their mental health services and reduce morbidity and mortality in students. We will present programs with training for psychiatry residents, psychiatry fellows, subspecialty fields, as well as a curriculum designed specifically for college mental health training. Residency training programs in general psychiatry have been creative in developing opportunities for residents to learn more about college psychiatry. Many programs have 3rd and 4th year rotations in student health centers. Other programs created a specialized track that spans residency. These experiences often including working on a multidisciplinary team, interacting with university resources, and providing outreach to students and the college community. There have been a handful of college mental health Fellowships that provide an additional training after residency. At our institution, a Student Mental Health

Fellowship position for psychiatrists was recently funded to encourage continued training in this field, and we will describe this program in detail. The Fellowship also incorporates cultural background, socioeconomic status, religious beliefs, and demands of specific academic programs in treatment. The Fellowship also offers a novel opportunity to gain subspecialized training working directly with student-athletes. Student-athletes may present with distinctive symptoms and syndromes related to athletics, including training/overtraining, stress of competition, injury, team dynamics, and balancing athletic and non-athletic endeavors. There are also unique considerations in prescribing medications, regarding side effect profiles that could potentially influence performance, as well as taking into consideration banned substances. Finally, our Training Director will describe the development and implementation of a college mental health curriculum. This will be followed by a panel discussion. Attendees can learn more about these programs and can also learn about how to implement such programs at

Modulating Aversive Memories in Psychiatry: From Rodents to Humans

Presenter: Kerry J. Ressler, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The learner will be able to describe new research across Patient populations and animal models into the neurobiology of PTSD.; 2) The learner will be able to discuss brain regions and neural circuits thought to underlie PTSD.; 3) The attendee will have further understanding of how childhood trauma effects adult risk and resilience to psychopathology.; and 4) The learner will be able to educate others on potential new treatment methods, as well as further understanding current approaches to treating PTSD.

SUMMARY:

Dr. Ressler will review the neurobiology of fear in animal models and in human fear- and stress-related related disorders such as Posttraumatic Stress Disorder (PTSD), Anxiety and Depression. He will also discuss our increasing understanding of the neurobiology of learning and memory within the

amygdala and prefrontal cortex, as it relates to fear and its inhibition via the process of extinction. Some of these advances include regional regulation of brain derived neurotrophic factor (BDNF) and its TrkB receptor, the NMDA partial agonist, d-cycloserine, and other putative mechanisms for promoting emotional learning and fear inhibition in animal models. Furthermore, cell-type specific approaches are leading to novel targeted understanding of amygdala and other emotional brain structures which will result in much more precise treatment and intervention approaches. In summary, advances in the understanding of the neurobiology of fear and extinction of fear learning may lead to exciting and powerful new approaches to treating PTSD and other anxiety disorders.

Moral Injury: A Call for a More Social Psychiatry

Chair: William Peter Nash, M.D.

Presenter: Christa Acampora, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain moral injury as a mechanism of harm resulting from social and moral — rather than physical — threats to personal integrity; 2) Review the emerging evidence for moral injury as a major public health challenge in military service members and veterans; 3) Consider other potentially morally injurious events unrelated to armed conflict; 4) Establish goals and compare emerging models for clinical treatment and rehabilitation of moral injury; and 5) Explore reasons the challenges posed by moral injury can best be met through integrative partnerships among diverse stakeholders

SUMMARY:

The rapidly emerging concept of moral injury challenges previous models of psychological trauma as a disorder of fear conditioning evoked by exposure to extreme physical danger. It also offers an explanation for why clinical treatments and prevention programs based on those models have been less successful than was hoped, particularly for psychological harm resulting from human agency. More broadly, the concept of moral injury and its emerging evidence base shed needed light on the central role played by meaning and morality in

wholeness and health, both within individual persons and between them in social groups. Our session will trace the development of the concept of moral injury in war and peace, and review the findings and implications of emerging moral injury research, including studies of potentially morally injurious events, moral injury symptoms and signs, and approaches to treatment. We will focus especially on what is known – and not yet known – about the relationship between moral injury and posttraumatic stress disorder (PTSD), suicide, and other important stress-related problems. We will also discuss the broader societal implications of moral injury and what it tells us about the fundamental role of morality and meaning in defining and sustaining personal identities and memberships in social groups. Finally, we will encourage discussion with participants about the role of psychiatrists in addressing moral injury, both in clinical settings and in communities.

“More Money, More Problems”: The Impact of Moonlighting on Trainees and Training Programs

Chairs: Nicole M. Benson, M.D., Scott R. Beach, M.D.

Presenters: Deanna Constance Chaukos, M.D., Daniel Shalev, M.D., Joshua Ryan Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the high prevalence of moonlighting by physicians-in-training and the impact moonlighting may have on their clinical work and education; 2) Understand the risks and benefits of moonlighting from the trainee and program perspectives, including its impact on physician wellness; 3) Provide strategies to Program Directors around offering supervision and guidance to trainees who engage in moonlighting; and 4) Provide strategies to trainees regarding seeking appropriate supervision when moonlighting

SUMMARY:

Moonlighting during residency is a common practice throughout medicine, and studies have suggested that 44.4%-69% of psychiatry residents engage in moonlighting at some point during training. As a result, most residency programs have developed policies and procedures around moonlighting, many of which are based on state laws regarding

independent licensure of trainees. Historically, residents across many disciplines have reported a desire to moonlight to supplement their income, enhance their education, and develop more independence and self-confidence. Many training programs have been supportive of the practice of moonlighting because it can provide residents opportunities to see different clinical settings, be exposed to different styles of practice and carry more responsibility for patient care decisions than in the training setting. However, the supervision of trainees while moonlighting is inconsistent, with just over half of trainees who moonlight reporting that they have supervision available to them. In this workshop, we will discuss some of the primary motivators for moonlighting by trainees, current moonlighting practices in trainees across the country, and the impact these practices may have on training, education, and wellness. We will explore the relationship between moonlighting and duty hours, as well as variation in types of supervision available to residents when moonlighting. To begin the panel, participants will be polled regarding their own experiences moonlighting and supervising trainees who moonlight. An invited panel of residents, moderated by a Residency Training Director, will discuss their moonlighting experiences during training. Audience participants will then be invited to share their involvement in moonlighting and supervising trainees who moonlight. We will strategize with participants about how to provide a supportive learning environment, recognizing the risks and benefits of moonlighting for trainees and for those supervising those trainees.

More Vulnerable Than We Realize: Lessons From Psychiatrists Who Were Stalked

Chair: George David Annas, M.D., M.P.H.

Presenters: James Lyle Knoll, M.D., William J. Newman, M.D., Kevin Lynn Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge on the current state of research regarding mental health professionals as stalking victims (with a focus on Psychiatrists and Psychologists).; 2) Become familiar with and understand the concepts of threat minimization, methods of early recognition, and

avenues to help with support and ways to cope after stalking.; and 3) Understand the experience of psychiatrist stalking victimization via two firsthand accounts from psychiatrists who were stalked

SUMMARY:

It is well known that celebrities and those holding public office are often vulnerable to being stalked. However, what is not as commonly known is that psychiatrists also have high lifetime prevalence, despite having such a low public profile, in comparison. For example a study in the United Kingdom found that even when the strictest research criteria were used, that 11% of psychiatrists reported at least one episode of lifetime stalking victimization (Whyte, et. al., 2011). Another study in the UK, noted that >20% of inpatient Psychiatrists had been stalked by a patient (McIvor et. al., 2008). Despite being experts in the field of mental health, neither general practice psychiatrists, nor forensic psychiatrists are any less vulnerable to this kind of victimization. In addition, those in the profession are just as apt to suffer the substantial social, psychological, and financial toll that being stalked can engender. Among our panelists are two seasoned forensic psychiatrists who will each describe the marked prolonged struggle they went through when victimized by a stalker, and how it almost ruined their lives. Notable issues that will be addressed include the limitations of what law enforcement can and are willing to assist with, the strain on one's personal life and career, and even after the resolution how much can be lost, as a result. This panel will also discuss the current research on mental health professionals as stalking victims, including the prevalence of psychiatrist and psychologist stalking victimization, the motives of perpetrators, the types of burdens the victims suffer, as well as common demographics of both perpetrators and victims. Based on the literature and first person narratives, the panel will address important lessons in the early recognition, risk management, and effective coping for a psychiatrist who becomes a victim of stalking.

Multilevel Engagement of Psychiatric Residents in an Innovative Jail Diversion and Reentry Program

Chair: Danielle Chang, M.D.

Presenters: Sonya Shadravan, M.D., Kristen Ochoa, M.D., M.P.H., Samuel Hitz, M.D., Viet Thuy Nguyen, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the concept and role of jail diversion and competency to stand trial; 2) Comprehend the scope of LA County's Office of Diversion and Reentry; combining diversion with interim supportive housing, case management, and supportive services; 3) Examine concrete ways in which Psychiatric Residents in training can be exposed to and engaged in multi-stage jail diversion work through anecdote and clinical cases; and 4) Explore opportunities for local partnerships between jail diversion programs and psychiatric residency educational endeavors

SUMMARY:

The correctional system is well-known to be the largest provider of mental health services in the United States. Los Angeles county jails, in particular, house over 17,000 inmates and the largest number of acutely psychiatrically ill individuals in the nation. Over the past decade, various diversion efforts have been developed in multiple jurisdictions that aim to minimize incarceration for these individuals, in favor of routing them into community based mental health services. While the acceptance of such programs has grown along with a sense of the multiple benefits and cost savings they potentially deliver, in practice it remains difficult to meet the scale of the possible diversion demand, which is particularly the case in the largest of these such programs to date, located in Los Angeles County. The need for increased engagement from appropriately trained and motivated psychiatric providers who can, among other tasks, provide timely assessments of competence to stand trial, deliver treatment to the mentally ill and incarcerated both in the jails as well as on acute forensic psychiatric units, and conduct assessments of mental health needs and assist in formulating appropriate community treatment plans in preparation for diversion court, has never been greater. In Los Angeles County, the Office of Diversion and Reentry (ODR), within the County's Department of Health Services, has undertaken

significant efforts to engage psychiatric residents at multiple stages of the jail diversion process in order to both leverage the reach and scale of its novel programs and attempt to minimize the length of undue incarceration for the mentally ill population, while simultaneously providing a rich training environment that augments resident exposure to the intersection of policy, advocacy, and clinical mental health. In this presentation, we will provide a brief introduction to the concept of jail diversion, while highlighting the experience and model of the Los Angeles County ODR, which has diverted and released over 2,000 persons since its inception in 2015. Special emphasis will also be placed on the multiple ways in which psychiatric residents in LA county have been engaged in participating in ODR's diversion work. This resident engagement ranges from performing competency to stand trial evaluations both in court as well as in LA county jails, performing mental health assessments and developing recommended treatment plans in felony diversion court, performing morbidity and mortality reviews of ODR clients, performing needs assessments, as well as treating Office of Diversion clients at Olive View Medical Center's forensic psychiatric unit and in jail to restore competency to stand trial.

Navigating the Quagmire of the Workers' Compensation System

Chair: Stephen G. Noffsinger, M.D.

Presenters: Meghan Musselman, M.D., Maria Lapchenko

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the four critical elements to evaluate in every Workers' Compensation assessment; 2) Analyze five mistakes commonly made in Workers' Compensation assessments.; 3) Know the main elements to include in Workers' Compensation reports.; and 4) Demonstrate knowledge necessary to write excellent Workers' Compensation reports.

SUMMARY:

The Workers' Compensation system has evolved into a complicated and adversarial bureaucracy of adjudicating claims for compensation and benefits

for physical and emotional injuries sustained in the workplace. Originally designed to streamline the processing of claims, the system is now complicated, unwieldy and often antagonistic. Employers are perceived as uniformly and unfairly contesting injured workers' claims, while workers are perceived as exaggerating their claims to achieve maximum benefits. Psychiatrists are frequently asked to evaluate worker's claims for psychological occupational injuries. Yet little training is available to navigate this complex system. This presentation will illustrate: 1. The historical development of the Workers' Compensation system; 2. The statutory and common law regulation of the Workers' Compensation system; 3. How to assess for the allowance of an occupationally-related mental disorder, aggravation of pre-existing mental disorder, Temporary Total Disability, Maximum Medical Improvement, and Permanent Partial or Total Disability; 4. How to write effective Workers' Compensation reports; and 5. How to interact with plaintiff and defense attorneys and third-party claims administrators.

Neuroscience-Informed Precision Psychiatry

Chair: Leanne Williams, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand definitions and goals of precision psychiatry; 2) To learn about a novel taxonomy for classifying mood disorders based on brain circuit understandings; and 3) To gain insight into how neuroscience measures can be used to guide clinical decisions

SUMMARY:

There are currently no clinically actionable measures of brain circuit function for psychiatry and mental health care. One approach to addressing this need is the development of a taxonomy of circuit-based "biotypes", that connect distinct malfunctions of neural circuits to distinct behavioral profiles. This session presents a novel approach to quantifying dysfunction in macroscale human brain circuits at the individual patient level. The focus is on macro scale brain circuits implicated in human functions of self-reflective thought, salience perception, attention, negative emotion processing, positive

emotion processing, regulation of threat and cognitive control. Disruptions in these functions are hallmarks of mood and anxiety disorders. A reproducible imaging system is demonstrated. This system quantifies brain circuits in a reproducible way necessary for translation into the clinic. It incorporates standardized definitions of each circuit, workflows for quantifying activation and connectivity within each circuit, and algorithms for computing circuit function. Results using this image processing system are presented for multi-diagnostic adult samples spanning diagnoses of major depression, generalized anxiety, social anxiety, agoraphobia, panic disorder, bipolar disorder type 2, social anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder. These samples include train, test, independent generalizability and pre-post intervention samples. The findings indicate that distinct brain circuit alterations in activation and functional connectivity map onto symptoms of anxious avoidance, loss of pleasure, threat dysregulation, and negative emotional biases, core characteristics that transcend mood and anxiety disorder diagnoses, as well as decreased satisfaction with life. These alterations also distinguish distinct profiles of responders and non-responders to first-line antidepressants, second-line antidepressants, behavioral therapy and neuromodulation interventions. These findings are illustrated with a series of case examples. It is concluded that the natural neurobiological variation in mood and anxiety disorders can be quantified in terms of brain circuit dysfunctions, that such a system is both feasible and necessary, and that profiles of circuit scores could be a valuable tool for guiding treatment choices in the psychiatry and mental health clinics of the future.

New-Onset Psychosis: What Trainees, Residents and Early Career Psychiatrists Should Know

Chair: Vasiliki Eirini Karagiorga, M.D.

Presenters: Tresha A. Gibbs, M.D., Iliyan S. Ivanov, M.D., Dolores Malaspina, M.D., Cheryl Corcoran

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review standard diagnostic tests and new differential diagnostic approaches, including research findings in neuroimaging and

potential genetic/epigenetic neurodevelopmental biomarkers.; 2) Identify existing risk and protective factors, including substance use, discuss future predictive models for conversion to schizophrenia and review clinical research data.; 3) Describe the course and outcome of new onset psychosis, typical and atypical clinical manifestations, common and uncommon comorbidities.; 4) Explain principles of interventions, including existing and emerging pharmacological interventions as well as psychosocial interventions, such as CBT for psychosis and creative arts therapy.; and 5) Engage in an interactive educational workshop with the opportunity to network with colleagues and leaders in the field of new onset psychosis.

SUMMARY:

This dynamic and interactive session will teach trainees and early career psychiatrists the fundamentals they need in order to improve their skills and level of comfort in early diagnosis and treatment of new onset psychosis. This session will also introduce participants to clinical research findings on emerging diagnostics and management strategies currently under investigation, and which will be soon incorporated into clinicians' routine practice. Through an interactive format, using the principles of discussion and reflection to explore clinical cases, participants will develop new skills to identify early psychosis, understand its course and potential outcomes, and how to apply existing treatment modalities. An exploration of emerging research tools and their current evidence will help participants consider their application to formulate innovative treatment strategies for challenging, complex, or treatment refractory cases. This session will be led by psychiatric professors and psychosis researchers from the Icahn School of Medicine at Mount Sinai, including the Director of the Psychosis Program.

Our Shared Responsibility: Helping Young Women and Men Overcome Adversity

Chair: Helen E. Herrman, M.D., M.B.B.S.

Presenters: Lian Zeitz, Pamela Yvonne Collins, M.D., Norman Sartorius, M.D., D.P.M., Ph.D., M.A., Moitreyee Sinha, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to describe examples of local, national, and global mental health responses that meet the needs of young people living in adversity.; 2) The participant will be able to understand the relationship between childhood adversity, recent stressors, and mental health challenges across the life-course; and 3) The participant will be able to evaluate current approaches used by cities, youth, and mental health professionals to address the impacts of cumulative stress/adversity experienced by young people

SUMMARY:

Adversity in childhood and adolescence lays the seedbed for lifelong human development challenges. A complex assortment of exposures, including violence, gender-based inequality, illness, certain genetic risk factors, displacement and livelihood threats related to climate change, and many others, create situations of adversity for young people. From the first years of life to transitions into adulthood, the exposure to and experience of adversity increases risk of mental health challenges and the development of mental illness. Adversity is also associated with poorer trajectories of sleep, risk of communicable and non-communicable diseases, and poverty. Our recognition of the importance of adversity on young people's development has influenced the way mental health professionals approach individual and public mental health challenges. During this panel presentation, leading global and national mental health experts will 1) discuss the factors to consider when addressing the needs of young people in adversity and 2) outline ongoing initiatives that address these challenges. Panelists will share emerging and evidence-informed approaches to mental health promotion and care that meet a range of needs for vulnerable or marginalized young people. The panel will conclude with a discussion on how the mental health community can take bolder steps to prioritize the needs of young people in adversity at local, national, and global levels.

Physically Self-Destructive Acts in Children, Adolescents, and Young Adults With Borderline Psychopathology

Chair: Mary C. Zanarini, Ed.D.

Presenters: Stephanie D. Stepp, Ph.D., Carla Sharp, Shirley Yen, Andrew Chanen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand the etiology of BPD in children, adolescents, and young adult offspring in more granular detail.; 2) At the conclusion of this session, the participant will be able to better provide treatment for self-harm and suicide attempts in children and adolescents with BPD.; and 3) At the conclusion of this session, the participant will be able to teach others about the etiology and treatment of self-harm and suicide attempts in young people with BPD.

SUMMARY:

Borderline personality disorder (BPD) is now recognized as a valid disorder in children, adolescents, and young adults. The most frightening symptoms of this disorder are episodes of self-harm and suicide attempts. There is a gap in our knowledge about the etiology of and most effective treatment strategies for dealing with physically self-destructive acts in borderline patients in this younger age group. Three of our presentations will focus on the etiology of these potentially life threatening or life altering behaviors. Two others will focus on evidence-informed treatments for these challenging symptoms. Dr. Zanarini will present preliminary findings from a study of the transmission of suicide attempts from parents with borderline personality disorder to their adolescent/young adult offspring. Dr. Stepp will present preliminary findings from the MOOD-Y study that found that parent emotional reactivity at baseline increases youth (ages 11-13) emotional reactivity and suicidal behavior over time. Dr. Sharp will present unique correlates of self-harm in the context of borderline psychopathology in a large sample of inpatient adolescents. Dr. Yen will report on preliminary findings pertaining to the STEP (Skills to Enhance Positivity) intervention that aims to decrease suicidal behavior in a high-risk sample of inpatient adolescents. Dr. Chanen will report results from a study of three randomized psychosocial interventions for self-harm and suicide attempts in BPD youth.

Promoting Mental Health of Medical Students, Residents, and Faculty: How Do the Institutional Aspects Impact the Health of an Academic Environment?

Chair: Arthur Danila

Presenters: Eduardo de Castro Humes, M.D., Amy W. Poon, M.D., Meera Menon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the interrelation between the wellness of students, residents, and faculty; 2) Recognize the impact of institutional factors on mental health; and 3) Discuss and elaborate institutional activities directed at different settings of an academic health system

SUMMARY:

Over the past decade, there has been a growing body of research on the mental health of medical students and residents. Some initiatives are underway, not only regarding those populations but also targeting faculty. Burnout and depression stand among the most prevalent conditions that affect the mental health of these populations and constitute a continuum that may lead to suicide. Most of those initiatives to reduce the burden of those conditions tend to be focused on an individual perspective, despite the evidence demonstrating that burnout is highly associated with the workplace. Stigma, demand to complete EMR, heavy workload, educational debt, low recognition and perceived lack of autonomy are highly associated with poorer mental health outcomes. Therefore no initiative will be fully successful if it ignores the need to address the institutional perspective. During this activity, we intend to meet our objectives through both didactics with a panel and small group discussions, delivering frameworks that may be applied to foster mental health of different academic environments.

Psychiatrist as Clinician-Educator: How to Give Effective Clinical Feedback

Chair: Thien Chuong Richard Ly, M.B.B.S.

Presenters: Auralyd Padilla Candelario, M.D., Erick Kwan Jo Hung, M.D., Tresha A. Gibbs, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the barriers to providing clinical feedback; 2) Describe key elements of effective clinical feedback; 3) Apply a model for effective clinical feedback discussion; 4) Analyze the RIME level of a clinical learner to identify strategies for improvement; and 5) Integrate effective clinical feedback strategies in your clinical environment

SUMMARY:

For clinician educators, the ability to provide feedback is essential in assisting trainees to reach their highest potential (1). However, numerous barriers exist in providing effective clinical feedback including time pressures, educational setting, limited training on feedback, unclear feedback purpose, lack of confidence in observations, uncertainty in how to translate observations into constructive feedback, other clinician-educator factors, and trainee factors. (1-3). Aimed at chief residents, fellows, and early career psychiatrists, this session will teach the key principles to providing effective clinical feedback to fellows, residents, and medical students. This session is adapted for a psychiatric audience with permission from Dr. Sally Santen based on her "Teaching and Assessing Clinical Skills" course from the University of Michigan (3). Through interactive presentation, video vignettes, small group discussion, as well as question and answer, participants will develop insight into Dr. Louis Pangaro's Reporter-Interpreter-Manager-Educator RIME model (4) and develop skills in giving effective clinical feedback in a succinct and practical manner. Participants will have the opportunity to practice these skills in session through role-play in order to feel more confident with integrating effective clinical feedback upon return to their current clinical practices.

Psychiatrists' Views on Self-Disclosure of Mental Illness: Symposium Data on When, Why, and How to Disclose?

Chair: Robert S. Marin, M.D.

Presenters: Claire MaChere Cohen, M.D., Michelle Georges, M.D., H. Steven Moffic, M.D., Raymond M. Reyes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Present psychiatrists'

experience managing the vulnerability and opportunity associated with self-disclosure of mental illness; 2) Evaluate the risks, benefits and approaches to disclosing one's own experience with mental illness and related emotional challenges; 3) Identify the ways self-disclosure contributes to physician wellbeing, prevention of burn out and reduction of stigma; 4) Individualize the approach to self-disclosure based on a person's age, ethnicity, race, gender and other sociocultural factors; and 5) Interact more effectively and empathize more fully with people who do and those who do not self-disclose

SUMMARY:

Is it helpful to tell others that we have a mental illness? If yes, when and to whom? Should we disclose only to psychiatrists or perhaps to others, such as residents, students, peer professionals, or other service users? And what about our patients? When is it helpful for our patients to know more about us and, in particular, is it ever helpful for them know that we have a mental illness, that we have had psychiatric treatment, been in therapy, or used medications? Finally, if self-disclosure is helpful, in what ways? Can self-disclosure serve to encourage others to seek treatment for themselves or as a way to model strengths that will help others reduce burnout, distrust of others, or fears of reprisal? The program is intended for all conference attendees, not just those who have mental illness. All of us are affected directly and indirectly by the systemic meanings of mental illness. The complexities of stigma and self-disclosure may call on us to respond appropriately when others make mention of their mental health challenges. The program has further relevance to our profession because measures to reduce burnout and improve physician wellbeing depend on psychiatrists' willingness to disclose their symptoms and functional problems. The overall goal of the session is to characterize the rationale, risks and potential benefits of psychiatrists disclosing to others their own journeys with mental illness and psychiatric treatment. It will be presented by a diverse faculty, diverse in age, gender, race and ethnicity. The panel's diversity will broaden the presentation's relevance to attendees and refine our ability to individualize the approach to self-disclosure based on sociocultural factors. We will

introduce the program by summarizing the evaluation data from our 2018 Annual Meeting symposium on self-disclosure. In narrative and small group interactions, we will describe our own journeys with mental illness and our experience with self-disclosure: to whom we have disclosed and what that was like, what we disclosed and why, and, perhaps most importantly, what the benefits were for ourselves and for others. Most of the program will be dedicated to attendees interacting with each other and with the panelists. Attendees will be invited to participate in small group discussions facilitated by program faculty who will present specific questions to facilitate the discussion of self-disclosure. The program will conclude with open discussion based on the presentations and small group discussions. Participants will be invited to make recommendations for further discussion, research and system change.

Psychiatry Side Gigs: How and Why Psychiatrists Are Supplementing Their Income

Chair: Abhisek Chandan Khandai, M.D., M.S.

Presenters: Elie Aoun, M.D., Christina M. Girgis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate non-financial benefits of part-time opportunities, including decreased burnout and increased psychiatric access for patients, while considering medical-legal and ethical issues; 2) Describe at least three additional ways by which general psychiatrists can supplement their income utilizing their skill sets; and 3) Practice negotiating part-time positions using real-life case examples through role-play scenarios

SUMMARY:

Nearly one in four Americans have more than one job, with Millennials in particular embracing the side gig economy as both alternative and adjunct employment (1,2). The emerging workforce increasingly values flexibility and innovation in employment, including within psychiatry: medical students are increasingly valuing fit with personality and work/life balance as primary reasons for choosing psychiatry (3,4). Concurrently, the US faces a growing demand for psychiatric services, particularly in rural areas and in underserved

populations, exacerbated by an aging psychiatrist workforce and the relatively static number of psychiatry residency spots (5). Finally, concern continues to grow around physician burnout, which is intrinsically linked with dissatisfaction with work-life integration and predictive of physicians leaving clinical work altogether (6). These seemingly disparate factors create new demands and opportunities for part-time opportunities both within and outside of traditional psychiatry, in part filling an unmet need as well as appealing to changing workplace values. Despite the potential benefits, awareness and exposure to side gigs remain sparse, and trainees report significant gaps in training around issues of compensation, career development and innovation (7). This workshop aims to inform participants about the numerous part-time job opportunities available to psychiatrists utilizing existing skill sets, while also covering medical-legal and ethical considerations, as well as actively engaging participants in developing negotiation skills around securing part-time offers. First, we will utilize informal online straw polling to assess audience familiarity with part-time psychiatric work. Then, we will present several non-financial benefits of part-time opportunities, including decreasing burnout and building skill sets, as well as increasing access to psychiatric services for patients. We will also discuss important medical-legal and ethical considerations prior to engaging in part-time positions, in particular issues of malpractice coverage and supervision for trainees. After an overview of various part-time opportunities for psychiatrists, ranging from moonlighting to telepsychiatry to utilization reviews to grant/test question writing, we will further engage the audience in role-play to practice negotiating for part-time positions using real-life case examples. Finally, we will end with general discussion and an exit straw poll to reassess audience comfort with and interest in pursuing part-time work.

Quality Improvement: International Perspectives

Chairs: Wolfgang Gaebel, M.D., John S. McIntyre, M.D.

Presenters: Wolfgang Gaebel, M.D., John S. McIntyre, M.D., Michelle B. Riba, M.D., M.S., Jerry L. Halverson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Cite three or more of the key indicators for quality improvement.; 2) Identify three barriers to quality improvement.; 3) Identify the processes that are helpful in creating a depression treatment manual on an inpatient service.; and 4) Identify key issues in the development of a project to ensure the use of practice guidelines.

SUMMARY:

This symposium is sponsored by the Section on Quality Assurance of the World Psychiatric Association. Two of the presenters are Chair and Co-Chair of the Section (WG and JM) and a 3rd presenter (JH) is also a member of this Section. The first presentation (Wolfgang Gaebel) will begin with a broad review of quality improvement principles following the IOM definition of quality as “the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge”. The presenter will describe recent advances in Germany in the systematic use of quality improvement initiatives across a broad range of treatment settings including the use of measures derived from practice guidelines. Specific psychiatric quality improvement initiatives and the strength and weaknesses of these projects will be reviewed. The second presentation (Michelle Riba) will focus on several key indicators for quality improvement and potential opportunities and barriers, with particular emphasis on low resources regions. Models of training will be addressed as a means to improve quality. Examples will be provided regarding how to initiate quality improvement activities and reduce potential roadblocks. The third presentation (Jerry Halverson) will describe the efforts in large behavioral health system to promote evidence based best practices for the treatment of depression on inpatient units. Through this process a depression treatment manual and associated medication algorithm was produced. The processes undertaken to roll out this project and ensure fidelity will be discussed. Data will be shared showing improved outcomes for depression, increased patient satisfaction and decreased cost. The fourth presentation (Jack McIntyre) will describe a project in upstate NY to measure the implementation of

practice guidelines. This grant funded project developed by a multi-stakeholder Quality Collaborative under the auspices of a county medical society used the GLIA (Guideline Implementability Appraisal) tool to pick guidelines for the project. Hypertension was the first guideline chosen and subsequently Major Depressive Disorder in Adults and Asthma in Children and Adolescents were studied. Obtaining the buy-in of physicians will be discussed and the results of the project to date will be shared.

Reducing the Risk of Workplace Violence: An Innovative Resident Safety Training Course

Chair: Uma Suryadevara, M.D.

Presenters: Jacqueline A. Hobbs, M.D., Richard Calvin Holbert, M.D., Dawn-Christi M. Bruijnzeel, M.D., Justin B. Wenger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the development, implementation, and evaluation of a safety training course that is designed to reduce the risk of violence in psychiatric treatment settings.; 2) Learn specific skills needed for identifying and preventing violent behaviors in an inpatient or outpatient psychiatric setting.; 3) Recognize signs of an escalating situation, analyze the threat level while conducting an on-going assessment of patient, self and environment.; and 4) Demonstrate appropriate skills to better ensure the safety of the patient and self.

SUMMARY:

Mental health professionals often work with patients who have increased risk factors for violence. Patient aggression against mental health professionals is often the most common form of violence that occurs in various clinical settings, such as emergency departments, psychiatric services, geriatric services and hospital waiting areas. Approximately 25–64 % of psychiatry residents reported a history of patient assault, and there is little evidence demonstrating that current practices related to safety training are effective. The safety training course taught in this session was originally developed for the psychiatry residents at the University of Florida to address this disparity and this session will help understand how to implement such a course in clinical settings.

Surveys have shown that the safety training course has been very helpful and the psychiatry residents and faculty felt calmer and more prepared to manage violence. During this session, we will review the prevalence of workplace violence, help psychiatrists develop an appreciation for how to conduct psychiatric interviews safely and take control of a dangerous situation while ensuring the safety of the patient and self. The session will describe the potential threatening situations and the importance of maintaining composure, which allows a physician to make better verbal and physical response decisions to ensure the safety of the patient and self. We will talk about the common attitudes amongst psychiatrists regarding workplace violence. Most people assume that violence is an inherent part of the job. This leads to under reporting and strengthens the belief that reporting would not change current practices. Through video illustrations of patient aggression, participants will be able to recognize the visible signs of agitation and employ de-escalation techniques to improve patient and staff safety. The physicians who are able to use the appropriate verbal and physical responses to patient violence will be subject to less physical injury to patient or self, less emotional trauma post incident, fewer missed days of work and decreased risk of potential liability issues. When there is heightened threat, a sense of helplessness can be a paralyzing emotion and lead to indecision. Having hands-on self-defense knowledge will give physicians the ability to maintain composure in life threatening situations. The last portion of the session will focus on videos that show hands on self-defense techniques appropriate for the patient care setting that will allow the psychiatrist to escape the threatening situation while keeping the patient and oneself safe.

Research Literacy in Psychiatry: How to Critically Appraise the Scientific Literature

Chair: Diana Clarke, Ph.D.

Presenter: Debra Gibson

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the principles of critical appraisal and its role in evidence-based practice.; 2) Understand the different basic study

designs, concepts, and level of quantitative evidence (i.e., statistics) in psychiatric research; 3) Understand why it is important for the individual psychiatrist to be able to critically appraise the scientific literature and interpret study concepts, designs, and statistics; and 4) Be able to critically appraise the scientific literature and judge its validity

SUMMARY:

The overall goal of this research literacy in psychiatry workshop is to help participants understand of what it means to critically appraise the scientific literature. Throughout the session, participants will be introduced to the basic concepts, study designs, and statistics in psychiatric research that will enable them to read and understand the scientific literature and appreciate the importance of being able to critically appraise the literature. Time will be allotted for participants to read a scientific article for discussion and critical appraisal of the article (i.e., 2-3 minutes per section - abstract, introduction, methods, results, discussion, conclusions, study strengths and weaknesses). The session will utilize a "journal club"-style interactive format in which methodological and statistical issues will be introduced and discussed on a section-by-section basis as they pertain to the scientific article. After the introduction of methodological and statistical issues related to each section, participants will be given 2-3 minutes to read that respective section of the article. Participants then will discuss the article, view it with a critical eye, and analyze and apply concepts learned. In summary, participants will learn how to appraise the scientific literature in a critical, thorough, and systematic manner. Not only will this 2-part workshop help attendees stay abreast of changes in the field and identify gaps in the literature; in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions. Participants are required to attend both parts of this workshop.

Risk Management and Legal Considerations: Can I Communicate With My Patient's Loved One?

Chair: Moira Wertheimer, Esq., R.N.

Presenter: Rebecca W. Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss patient privacy issues that can arise when treating patients.; 2) Understand the common legal pitfalls regarding disclosure and discuss when and when is it not appropriate to disclose information to family members.; 3) Provide a case example which has potential to impact psychiatrists treating patients and communicating with family members.; and 4) Identify strategies to minimize risk by adopting best practices to avoid professional liability claims.

SUMMARY:

Often family members or loved ones are involved in your patients' treatment and the question arises about what information can be conveyed to them and under what circumstances is disclosure permissible, particularly when there is no documented consent. Federal and state privacy rules strictly regulate the disclosure of protected health information (PHI), but there are situations where disclosure of PHI is permitted absent consent. This presentation discusses permissible PHI disclosures in situations where your patient refuses to allow involvement in treatment or communication with others, times when you begin to treat a patient who is a minor and over the course of his treatment, he reaches the age of consent, and times where it may be vital to convey your patient's care to have involvement of family members in treatment. In addition, this presentation will review protecting patient confidentiality when utilizing interpreters, assisted listening devices, or a TTY to convey PHI. This presentation will be co-presented by a risk manager from the APA-endorsed professional liability program and a psychiatrist. This presentation will provide a case presentation and the various legal, risk management and clinical issues that can impact decisions to involve family members in the treatment. This program will discuss strategies to minimize risks and potential liability. Particular attention will be paid to multi-cultural issues that can impact treatment.

Self-Documentaries Through Filmmaking and Photovoice: New Tools for the Humanistic Mission of Psychiatry

Chair: James Lamont Griffith, M.D.

Presenters: Laura Doggett, Sauharda Raj, Brandon Alan Kohrt, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to describe why inclusion of patients' and subjects' first-person experiences strengthens validity of studies.; 2) Participants will be able to describe how technological advances in photography, video, and film-making have opened new avenues for inclusion of subjects' first-person perspectives.; 3) Participants will be able to articulate how photovoice and self-documentaries can promote mental health by expanding voice, mobilizing agency, and creating community.; 4) Participants will be able to describe the value of photovoice and creation of self-documentaries when populations are remote or have suffered historic marginalization or discrimination.; and 5) Participants will be able to describe how photovoice and creation of self-documentaries can serve useful roles in anti-stigma interventions.

SUMMARY:

Psychiatry historically has relied upon empathic psychotherapists and ethnographers to interpret the lived experiences of people with mental illnesses or mental health problems due to harsh life circumstances. However, technological advances in photography, video, and film-making can now place the camera in the hands of the subject, opening new avenues for inclusion of subjects' first-person perspectives. These innovations expand scope of expression beyond narrative texts to visual images of subjects' daily lives. In this workshop, we illustrate such methods by showing: (1) Brief films produced by Syrian refugees from the "Another Kind of Girl Collective" (AKGC) in the Za'atari refugee camp in Jordan. These self-documentaries by teenage girls from rural Syrian villages utilize visual storytelling that adds complexity, nuance, and normality to the graphic trauma narratives told by mainstream media about refugee camps. The girls describe how voicing personal stories through film-making has transformed their identities, aspirations, and creation of community. AKGC self-documentaries have been screened at international film festivals including Sundance, Cannes, and South by

Southwest; (2) Use of photovoice in an NIMH-funded study to train mental health service users and their caregivers in stigma-reduction and health system strengthening in Nepal. Photovoice is participatory research in which service-users are taught to use photography as an advocacy and empowerment tool. With photovoice, service-users utilize photographs from their homes and communities to tell stories of recovery, covering topics such as mental health stigma, "coming out" as a mental health service user, and distress management. They become co-facilitators in the mental health training of primary healthcare workers and in community forums where they tell their stories of recovery and interact with members of local communities; (3) Use of photovoice in the APA-sponsored Central Appalachian Project seeking to expand access to mental health services in rural Virginia, Tennessee, Kentucky, and West Virginia. Inclusion of subjects' first-person experiences using these technological advances strengthens reliability and validity of qualitative research. These methods hold particular value for populations who are remote or who have suffered historic marginalization or discrimination that silenced self-expression. In direct impacts upon subjects, these methods constitute potent humanistic interventions that strengthen mental health through empowerment that expands voice, mobilizes agency, and creates community.

Sexsomnia: Clinical and Forensic Issues

*Chair: Brian James Holoyda, M.D., M.B.A., M.P.H.
Presenters: Susan Joy Hatters-Friedman, M.D., Amir Mohebbi, M.D., Renee M. Sorrentino, M.D., Antonio Fernando, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the epidemiology, pathophysiology, and phenomenology of parasomnic sexual behavior; 2) Describe how sexsomnia has presented in the context of criminal cases; and 3) Provide recommendations for the evaluation of claims of sexsomnia in forensic contexts

SUMMARY:

Sleep-related sexual behavior, or sexsomnia, may result from a variety of underlying neurologic, medical, or psychiatric etiologies, or it may arise

from an independent sleep disorder. Though recently recognized in the Diagnostic and Statistical Manual of Mental Disorders as one behavioral manifestation of non-rapid eye movement (non-REM) sleep arousal disorders, sexsomnia has been a long-recognized phenomenon. The diagnosis of sexsomnia and its etiology may be difficult because it commonly relies on an individual's history and because there are frequently multiple comorbid sleep disorders in individuals presenting with parasomnic behavior. Sexsomnia creates a risk that an individual may engage in unintended and nonconsensual sexual behavior. Cases involving sexual violence during sleep have been identified in case reports dating from 1980. Some of these cases involve single incidents of sexual misconduct and others involve repeated offenses. In cases where an individual puts forth sexsomnia as a defense for their alleged sexual offense, the court may call upon the assistance of forensic evaluators to clarify whether the individual has a genuine sleep disorder resulting in sexsomnia. Sexsomnia is therefore a relevant concern for psychiatrists, including those conducting clinical assessments and those involved with the forensic evaluation of sleep-related sexual behavior. In this session we will review the epidemiology, pathophysiology, and phenomenology of sexsomnia. We will describe how sexsomnia has become a contentious consideration in cases of alleged sexual offending. Lastly, we will delineate practical guidelines for the appropriate evaluation of individuals reporting sleep-related sexual behavior in both clinical and forensic contexts. We will engage audience members with didactic instruction, media, and case presentations demonstrating the role of sexsomnia in various criminal proceedings. We will also utilize straw polling to obtain audience opinion on various questions related to the clinical and forensic issues related to sexsomnia.

The Behavioral Education and Support Team: A Collaborative Multidisciplinary BEST Practice for Behavioral Dyscontrol

Chair: Kurtis Kaminishi

Presenters: Tia-Elisabeth Mulligan, M.D., Elizabeth Sutherland, Kewchang Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe a collaborative multidisciplinary approach to addressing behavioral dyscontrol in inpatients; 2) Recognize how educating physicians and medical-surgical nurses about managing behavioral dyscontrol can lead to improved outcomes for both patients and staff; and 3) Identify new approaches to addressing behavioral dyscontrol in one's own institution

SUMMARY:

It is commonly accepted that the first-line interventions for inpatients with agitation should be behavioral, rather than pharmacologic. However, in many inpatient settings, the consultation-liaison (C-L) psychiatry team's focus when making recommendations is pharmacologic, in part because the implementation of behavioral interventions is time-intensive. Additionally, when resources to staff a C-L team are limited, psychiatrists are often prioritized over other disciplines, and in the traditional consultation model, the decision to request a consultation is made by the physicians on the primary team, who then consult their own colleagues. With our rapidly aging population, the diagnoses of delirium and dementia in the inpatient setting are becoming more prevalent. These patients are at high risk for behavioral dyscontrol, and yet physicians, many of whom have been trained in a traditional medical model, and medical-surgical nursing staff are often ill-equipped to manage them. The risks to staff, other patients, and visitors can be considerable; patients with behavioral dyscontrol may assault others, for example, or may wander and provoke an incident. If police are called to assist, this may feel disruptive to some. Furthermore, nursing staff who are focused on trying to calm an agitated patient may be unable to provide a high level of care to others. At this workshop, we will discuss the work of the Behavioral Education and Support Team (BEST), which was launched at the San Francisco Veterans Affairs Health Care System in October 2015. BEST is an innovative multidisciplinary team of two nurses, a psychologist, a psychiatrist, and an occupational therapist, all of whom work with physicians and nursing staff on the medical-surgical wards to assist with patients who have behavioral dyscontrol. Because of the interprofessional nature of the team, they are able to educate others on how

to care for such patients in a multifaceted way, leading to enhanced patient care and increased staff safety. We will provide an overview of BEST, including its model of care and implementation. We will present case examples and qualitative data about BEST consults and outcome data about effectiveness. We will also discuss potential next steps that BEST can undertake to further improve patient care and staff morale. This will be followed by a panel discussion with input from the audience regarding innovative approaches to behavioral dyscontrol.

The Changes, Challenges, and Conquests of CPT Coding in 2019!

Chair: Vikram N. Shah, M.D.

Presenter: Nancy Gregowicz, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify appropriate Evaluation and Management (E/M) CPT codes and add on codes for services provided through participation in a mock audit of sample cases.; 2) Understand Centers for Medicare and Medicaid Services changes to E/M CPT coding guidelines and reimbursement as well as potential new CPT codes eligible for reimbursement in 2019.; and 3) Understand the documentation requirements for CPT codes used by psychiatrists.

SUMMARY:

Throughout the past several years, there have been many changes to the CPT coding process which has been challenging to psychiatrists and other mental health professionals. This workshop will cover CPT coding for Evaluation and Management services along with applicable add on codes as well as other CPT codes eligible for reimbursement by Centers for Medicare and Medicaid Services (CMS) in 2019. The session will include updates from Centers for Medicare and Medicaid Services (CMS) on the Evaluation and Management CPT Codes which includes using medical decision-making or time instead of applying the current 1995 or 1997 documentation guidelines. Coding documentation options will be reviewed including the history and examination sections which allows clinicians to focus on what has changed since the last visit rather than re-documenting all information including

information in the medical record that is entered by ancillary staff. Additional discussion will focus on CMS's proposal for reimbursement for virtual check-ins, remote evaluation of pre-recorded patient information and interprofessional internet consultation, During the session, attendees will play the role of a professional coder and review case scenarios to heighten their understanding of the coding process. The participants will then review the case scenarios as a group and the coding experts will provide feedback on the applicable coding. At the completion of the workshop the attendees will be able to understand the 2019 CMS CPT coding changes and appropriately choose the CPT codes for their services provided.

The Impostor Syndrome: International Medical Graduates Navigating Immigration Challenges and Beyond

Chairs: Lama Bazzi, M.D., Ramotse Saunders, M.D.

Presenters: Muniza A. Majoka, M.B.B.S., Ali Maher Haidar, M.D., Elie Aoun, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the "Impostor Syndrome" in general and how it affects IMGs in psychiatry residency in particular; 2) Participant will understand the unique challenges faced by IMGs who require visa sponsorship at the beginning of and during residency, while pursuing fellowship, and during their early career; 3) Participants will understand how acculturation and assimilation play into IMGs learning the American health care system; 4) Participants will appreciate the key role IMGs play in providing healthcare to patients living in under-served areas; and 5) Participants will appreciate the paucity of resources available to IMGs to address their needs in practicing in the United States and understand the innovative ways IMGs overcome these hurdles

SUMMARY:

International Medical Graduates (IMGs) make up about 25% of all psychiatry trainees in the United States. The current political climate surrounding immigration is particularly contentious and doctors from certain countries have had difficulty obtaining visas to join or continue in their residency programs.

Despite the American Psychiatric Association recently taking a stance in the defense of IMGs, international physicians continue to face unique challenges in seeking training in the United States. Residency training is a particularly demanding time in the life of any psychiatrist, and IMGs must overcome hurdles in addition to those considered routine. IMGs may face separation from family members, language barriers, being unfamiliar with the American healthcare system, as well as visa issues, which can be particularly stressful. These challenges are particularly magnified in the current climate of restricted borders, divisive opinions, and increasingly vocal conversation on immigration. IMGs must learn to provide medical care to a population that may not be accustomed to working with foreign physicians, adding a layer of complication to working with already challenging psychiatric patients. While some studies have shown that IMGs would use resources to prepare themselves for residency, if available, there is a paucity of resources directed at IMGs starting psychiatry residency. As such, IMGs may become prone to anxiety, depression, and burnout; however, they are unlikely to seek help for fear of losing their position and the opportunity to train in the United States. Even when IMGs graduate from residency, visa issues continue to affect their fellowship choices, as their positions are often limited by the programs that are able to sponsor their visas. This continues well into an IMGs early career, and the need for sponsorship often limits IMGs to practicing in under-served areas in order to fulfill visa requirements and stay in the country. Although IMGs must work as hard as American graduates to secure a residency position in the United States, they often suffer from the “imposter syndrome” and have difficulty internalizing that they have achieved their successes on their own merits. Our workshop will use the personal experiences of our panelists to illustrate each of the challenges faced by IMGs and demonstrate how different panelists used different strategies to overcome hurdles. The goal is to engage the audience in an open dialogue on their views of IMGs, the roles IMGs play in serving communities, and how IMGs can be better integrated and assimilated into our professional communities so that they can better serve patients and build careers in the USA.

The New Field on the Block: Palliative Care Psychiatry

Chair: Danielle M. Chammas, M.D.

Presenters: David C. Buxton, M.D., Keri Brenner

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Illustrate a variety of clinical scenarios where psychiatry offers useful knowledge and techniques for the field of palliative care; 2) Define palliative care and understand its role in our healthcare system, including the various specialties and interventions that comprise the field of palliative care; 3) Distinguish psychiatry’s unique skills that bolster the work and efforts of the field of palliative care; 4) Review basic treatment methods employed by palliative medicine providers that are relevant for practicing psychiatrists, delineating similarities and differences between the specialties; and 5) Formulate practical ways in which psychiatrists can incorporate palliative psychiatry into their clinical practice

SUMMARY:

Palliative care is a field of medicine focused on improving quality of life for patients and families who are facing life-threatening illness. Through comprehensive management of physical, psychological, social and spiritual issues, palliative care strives to prevent and relieve suffering (1). Palliative care values an interdisciplinary approach to treatment due to the dynamic nature of suffering with life-limiting illnesses. There are, however, limited psychiatrists on palliative care teams despite the fact that psychiatry’s particular skills and knowledge offer immense benefit to palliative care, especially given the significant burden of mental health issues in this population (2). Psychiatrists contribute by their expertise in mental health diagnosis, psychopharmacology, management of difficult conversations, formulation of interpersonal dynamics, clarification of values, acute crisis management, and psychotherapy interventions tailored to existential distress, demoralization, and bereavement (3, 4, 5, 6). In addition, psychiatrists help to minimize burnout on treatment teams. Hospice and Palliative Medicine is a board-recognized subspecialty of psychiatry despite the

fact that most general psychiatrists receive almost no focused training in this subspecialty and even fewer go on to complete a fellowship. Furthermore, patients with mental health illness have been proven to die earlier than the general population for multifactorial reasons, with a range of 13-30 years shortened life expectancy (7). It is imperative that psychiatrists have a basic knowledge of best palliative practices and how to collaborate with palliative providers, as many chronically mentally ill patients trust and rely upon psychiatrists exclusively for their medical needs. This general session will be led by fellowship-trained physicians boarded in both psychiatry and palliative medicine, offering a unique perspective at the nexus of these two fields. The session will offer practical strategies for optimal partnerships between psychiatry and palliative care in addition to a clear overview of the overlap between the two fields. The session will guide clinicians to a deeper understanding of the psychological and psychiatric nuances that can arise in association with serious or terminal illness, and experienced palliative care psychiatrists will discuss their approaches to these. Speakers will present concrete ways that their training in palliative medicine has impacted and enriched their practice of psychiatry. This will include both palliative principles that can be infused into psychiatry practice and tips for managing patients with life-limiting illness. Speakers will present their innovative approaches to working as psychiatrists in the field of palliative care, leaving time and space for some discussion with audience about areas for synergy and fruitful collaboration. Their expertise hopes to deepen psychiatrists' familiarity with palliative care and catalyze future partnerships between these specialties.

The Opioid Epidemic: From Freud to Fentanyl

Chair: Anna Lembke

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe opioid prescribing trends from 1995 to the present; 2) Identify invisible incentives inside of medicine driving opioid overprescribing; and 3) List strategies hospitals and health care providers can adopt to target the opioid epidemic

SUMMARY:

We are in the worst opioid epidemic in U.S. history, due in large part to opioid overprescribing to treat pain. From 1999 to 2016, more than 200,000 people died in the United States from overdoses related to prescription opioids. Overdose deaths involving prescription opioids were five times higher in 2016 than in 1999. How did we get here? Why are opioid overdose deaths continuing to rise, despite heightened awareness and public health interventions? What needs to happen moving forward to target this crisis? I combine national data, cultural anthropology, and neuroscience, to argue that the opioid epidemic is a symptom of our faltering health care system. The problem of opioid overprescribing, which continues to the present day, is driven by a complex web involving the pharmaceutical industry, the industrialization of medicine, the medicalization of poverty, and modern conceptions of pain.

The Power of the Pen: Keys to Success for Clinicians Writing for Popular Media

Chair: Shaili Jain, M.D.

Presenter: Nathaniel Morris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the essential steps to writing a successful pitch for popular media outlets; 2) Explore common pitfalls and mistakes made by Clinician writers; 3) Identify key resources, media outlets and venues where Clinician writers can pitch their work; and 4) Using a small group format, work on honing a pitch and then they themselves can practice this pitch and get real time feedback

SUMMARY:

The power of the pen to change hearts and minds cannot be underestimated. This is particularly salient to the area of mental illness which remains inaccurately portrayed and stigmatized in popular culture. It is vital that mental health professionals communicate with the public by publishing editorials, essays and commentary in the popular media. The act of communicating accurate and balanced information, via the popular media, to the public is an act of advocacy for patients and the

profession The digital age has seen the creation of ample outlets where mental health professionals can publish their writing. Beyond newspapers and magazines, clinician writers can now choose from websites, social networking sites and blogs. This said, success in publishing in such forums is not guaranteed, rather clinician writers need to develop the necessary tools and strategies to ensure their work will be accepted for publication. Our session will guide participants on the essential steps to writing a powerful pitch. We will also highlight common mistakes and pitfalls encountered by clinician writers. Participants will be provided with resources for media outlets which welcome science writing by clinicians and how best to go about contacting and pitching these outlets. The session will also allow for participants to hone and practice these skills and to receive real time feedback on how to improve them.

The Role of Family Dynamics and Family Work in Chronic Medical and Psychiatric Illness in Children and Adolescents

Chair: Susan Samuels, M.D.

Presenters: Susan Samuels, M.D., Matthew Shear, M.D., Gabrielle Helen Silver, M.D., Jonathan Avery, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will have a broad understanding of how family dynamics can contribute to the evolution and perpetuation of complex chronic illness in youth.; 2) At the conclusion of this session, participants will understand various multidimensional familial psychological conflicts in youth with eating disorders, substance use disorders, and medical illness.; and 3) At the conclusion of this session, participants will be able to identify basic principles of family treatment as they pertain to working with youth with complex chronic illness.

SUMMARY:

In the face of chronic medical or psychiatric illness in children and adolescents, family dynamics should be examined closely, and some form of family treatment may be essential for optimal recovery.

Children and adolescents' psychological interdependence on their caregivers can contribute to the evolution and perpetuation of the child's ongoing illness. Working with these families to bring the system into a more appropriate developmental path, allowing for normal evolution of cognitive and emotional independence can improve outcome tremendously. Many child psychiatrists, and, in particular consultation-liaison psychiatrists, are often the first mental health professionals to prepare families for ongoing treatment, to help these families in crisis become more engaged in treatment, and to provide psychoeducation. As examples of such complex circumstances, the diagnoses of eating disorders, addiction, and other medical illness in youth all pose similar multidimensional family conflicts, such as: the loss of the expected self or the hoped-for child, potential for ongoing disability, loss of control, and loss of faith in a parent's capacity to protect a child, all of which may need to be addressed in working with these families. One area of treatment for hospitalized youth with eating disorders that is empirically supported is family-based treatment (FBT). Hospitalization on a specialized inpatient eating disorders unit can provide an opportunity to mobilize and empower families to participate in treatment. Such units can do this in a number of ways, including incorporating family meals into the hospital treatment. Principal among goals is to help prepare and families to assume the role of refeeding their sick children upon discharge. Adolescent substance use disorders, also often requiring a unique skill set, will be covered, in particular the role of the family in the adolescent's substance use and treatment. Substance use in families has changed over the years, and there are improved treatment modalities which involve every member of the family. These options include Family Support Network (FSN) interventions, Multidimensional Family Therapy (MDFT), and Community Reinforcement and Family Training (C.R.A.F.T.), among others. There are also a range of on-line tools for the whole family. Finally, because chronic medical illness in children and adolescents can pose significant psychosocial and, in particular familial stressors, it is essential to understand how these stressors can lead to or be complicated by the involvement of various family members. The role of

caregivers can both positively and negatively impact the adherence to the medical regimen, as well as the short and long-term prognosis; the impact of family involvement portend these patients' overall quality of life, and, as a result, any related psychiatric symptomatology. General principles for assessing and working with family units in this population will be discussed.

Training Physician-Scientists in Psychiatry: A Road Map to Academic Success

Chairs: Antonia New, M.D., Maria Mercedes Perez-Rodriguez, M.D., Ph.D.

Presenters: Drew Kiraly, M.D., Ph.D., Kenechi G. Ejebe, M.D.

Discussant: Rene S. Kahn, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current status of the physician-scientist workforce in psychiatry; 2) Understand why physician-scientists are needed to bridge the bench-to-bedside gap in psychiatry; 3) Describe the challenges in recruitment and retention of a diverse workforce of physician-scientists; 4) Describe the components of a successful research track program in psychiatry; and 5) Describe some of the strategies to bridge the transition from residency to faculty and research independence

SUMMARY:

While funding and discoveries in neuroscience have grown exponentially over the past few decades, the physician-scientist workforce that is required to translate these research findings to the bedside has remained stagnant. In fact, throughout this "neuroscience revolution", the percentage of MD/PhD graduates entering residency training in psychiatry has remained mostly unchanged at only 5%. Not surprisingly, this has contributed to an enormous practice gap (i.e., it can take many years before critical findings from neuroscience research are implemented in psychiatric practice and can have an impact on individual patients). The goal of this session is to present the current status of the physician-scientist workforce in psychiatry, and to discuss challenges and novel strategies for enhancing recruitment, training and retention of a diverse workforce of physician scientists.

Specifically, we will discuss: 1) Strategies to train physician-scientists who can successfully compete for NIH or other federal and foundation funding by the end of their residency training; 2) How to bridge the transition to faculty and research independence; 3) NIH funding mechanisms for physician-scientists; 4) Financial and other incentives for a research career, and closing the pay gap between research and clinical positions; 5) Key challenges and strategies for fostering diversity in the physician-scientist workforce, including women and underrepresented minorities; 6) Novel approaches to provide and support research training to non-PhD psychiatry residents. We will discuss alternative paths to obtaining a PhD during residency, such as the NIMH-funded combined residency plus PhD program at the Icahn School of Medicine at Mount Sinai. Participants will be engaged in the session using several strategies: 1) There will be live polling of attendees at the beginning and end of the session to compare their a priori knowledge of the learning objectives with enhanced knowledge after the session; 2) We will provide first-person perspectives from physician-scientists residents and recent graduates; 3) We will provide real-life examples including vignettes and role-playing to illustrate relevant points; 4) We will schedule ample time for Question and Answer interaction with attendees to encourage rich discussion with the expert panel.

Transgender Mental Health Care for Undocumented and Underserved People in the New Era of Anti-Immigration Policy

Chair: David Tran, M.D., M.P.P.

Presenter: Melissa Rosenberg

Discussant: Zachary Davenport

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the importance of a safety-net health system in San Francisco; 2) Learn about the role of safe clinical spaces for undocumented patients; 3) Recognize barriers for undocumented and underserved transgender people; and 4) Understand the complexities of providing mental health letters of support for gender affirming surgeries

SUMMARY:

In the last decade, transgender health care has advanced significantly. Since the Affordable Care Act, most insurance companies cover transgender-related care and it is illegal to discriminate against transgender people. Despite these advances, transgender people continue to tremendously lack access to quality health care due to several barriers including but not limited to lack of health professionals with expertise in transgender health, lack of (and inadequate) insurance coverage, discrimination, and transphobia. For those who are uninsured, undocumented, or homeless have the worse access to care, unfortunately. Fear of arrest and deportation deter those from seeking necessary care. In this era of new anti-immigration policy, care provided to our most vulnerable population has become ever so important. To address these barriers, the San Francisco Department of Public Health established the Gender Health SF and Gender Mental Health Services to provide access to transgender-related services. In 2012, transgender surgery was removed from the list of excluded services under the Healthy San Francisco Program, health coverage for uninsured San Francisco residents. Gender Mental Health Services has been around since the 1990s. The clinic provides weekly psychotherapy, case management, group therapy, and psychiatric medication support services. Clinicians also provide assessments for letters of support for gender affirming surgeries. In this session, participants will learn to recognize barriers for undocumented and underserved transgender people. Participants will learn about evaluations from case presentations for gender affirming surgeries in the context of trauma-informed and culturally-aware care (care also provided in different languages). This session will also offer participants an opportunity to discuss with our panelist of clinicians on the workings and protocols of the clinic to provide a safe space for transgender patients who are undocumented.

Treating Heroes: Reaching Out to Our Hurricane and Disaster Responders

Chair: Philip M. Yam, M.D.

Presenters: Christine A. Winter, D.O., Jason Alan Anthes, D.O., Jonathan Q. Bui, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the unique strengths and challenges of disaster responders.; 2) Define DSM-5 updates and outline changes to Posttraumatic Stress Disorder as it relates to members of this occupation.; and 3) Display effective interview skills and rapport-building techniques that lead to best outcomes when treating first responders and rescue workers.

SUMMARY:

“Semper Paratus” is the official motto of the United States Coast Guard, which means “Always Ready.” In 2017, Hurricanes Irma and Harvey took 241 lives and inflicted \$190 billion in damage. Thousands of people were rescued and even more were displaced from their homes. In the face of horrible tragedy and peril, heroism arose in the incredible efforts and sacrifice of volunteers, first responders, and military members. In previous tragedies such as Hurricane Katrina, over 10% of first responders developed symptoms suggestive of posttraumatic stress disorder. Psychological responses to traumatic events differ between the disaster victims and the rescue workers themselves. As both witnesses and potential victims themselves, rescuers experience dangerous situations and must later reconcile conflicting feelings of service and sacrifice. In an engaging workshop, the presenters will discuss current literature and case studies of disaster responders noting their challenges and paths to recovery. The presenters will share highlights from their personal experiences, which includes their perspectives from serving as a tsunami responder, a combat medic, and a firefighter. Multiple choice questions and attendee participation will be utilized to spark conversation, exchange of ideas, and enhance clinical practice.

Undoing Stigma Through Entertainment: Lessons From Psychiatrists Interfacing With Pop Media

Chair: Praveen R. Kambam, M.D.

Presenter: Vasilis K. Pozios, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the role of entertainment media in potentially perpetuating and reinforcing stigma and social prejudice against

individuals with mental illnesses.; 2) Appreciate the potential underutilized opportunity entertainment media represents to reverse such stigma and social prejudice.; and 3) Recognize limitations to existing anti-stigma efforts and provide potential routes to further advance mental health advocacy.

SUMMARY:

Mental health stigma kills by discouraging people from seeking help because of fear and shame. Although mental health awareness has improved, stigma persists. How do we end it? The misrepresentation of mental illnesses in mass media is, arguably, the largest contributor to mental health stigma because media shapes culture and, in turn, our perceptions of people living with mental illnesses. Can we responsibly entertain audiences acculturated to inaccurate and stigmatizing mental health depictions? How have other historically under/misrepresented groups fared in fighting negative stereotypes through media? Does mental health stigma present different challenges that require unique solutions? Forensic psychiatrists and co-founders of the mental health and media consulting group Broadcast Thought, Praveen R. Kambam, M.D., and Vasilis K. Pozios, M.D., will present their innovative strategy to end stigma by shifting the paradigm of mental health media representation. They will provide historical context to the evolution of mental health representation in entertainment media and compare it to representation of other under/misrepresented groups. Drs. Kambam and Pozios will discuss how best to effect change in the entertainment industry through the active engagement of content creators, demonstrating that entertainment and advocacy need not be mutually exclusive. By understanding the principles of storytelling, mental health advocates can more effectively consult writers and producers and even create mental health-themed content themselves. Conversely, consultants can help the entertainment industry learn from the moving life stories of those in recovery while mindfully managing brands and avoiding embarrassing public relations missteps. Innovative and responsible mental health media representations can move depictions of mental illness beyond existing tropes into new and

compelling directions, changing audience perceptions in the process.

Using Motivational Interviewing in Patients With Schizophrenia

Chair: Michael A. Flaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the meaning of the “paradoxical effect of coercion” and its implications; 2) Discuss the overlap between the core components of the “spirit” of MI and those of mental health recovery; and 3) Discuss the key difference between a “shared decision making” conversation and an MI conversation with a patient who is reluctant to take medications that the clinician recommends.

SUMMARY:

Motivational interviewing (MI) was initially developed in the 1980’s as an approach to help those with addictive disorders. Over the past few decades, its use has broadened markedly across a variety of target behaviors, populations and disciplines. However, its application in psychiatry, outside of co-occurring addictive disorders, remains surprisingly limited in light of its potential. In this case conference, the use and promise of motivational interviewing in patients with psychotic disorders will be discussed and demonstrated. MI involves both a set of technical skills involving specific aspects of how we use language and communicate with our patients, as well as a “spirit”, or a way of being with our patients. While the evidence base for its effectiveness in patients with schizophrenia remains limited, the presenter hopes to demonstrate its potential utility in this population, not only as a tool one may pull out the toolbox for a particular clinical issue (such as treatment non-compliance), but as a potential default communication style and way of being with our patients, including those on the most severe end of the severity spectrum. For those less familiar with MI, a brief overview of its foundational ideas will be discussed, focusing on the so-called “paradoxical effect of coercion” and its profound implications in terms of how we as clinicians see our roles, and how we choose to spend the limited time we have with our patients. The importance of “resisting the

righting reflex”, i.e., the need to actively suppress our inclination to try to “fix” our patients will be discussed, in the context of what that leaves for us to do that is worthwhile and therapeutic. This relates to the consonance of MI with that of a recovery-oriented approach to working with patients with serious mental illness. For those who are more familiar with MI, there will also be some discussion of clinical situations in working with seriously mentally ill patients with different types of psychopathology, in which it may be necessary and appropriate to modify aspects of a traditional MI approach. It will also be suggested that the level of conviction regarding delusional beliefs may be approached analogously to the way we approach ambivalence in MI. Finally, there will be some discussion of the overlap and differences between MI and shared decision making. Note that as actual patient video’s will be used for demonstration, this session will not be recorded and the presenter requests that no pictures, video or audio recording be taken during the session.

Using Stem Cell Models to Study Psychiatric Conditions: Update on Gene Editing Tools, Single Cell Transcriptomics, and Drug Responsiveness

Chair: Carol Marchetto

Presenters: Sara Linker, Lilia Iakoucheva, Cathy Barr, Krishna Vadodaria

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the use of induced pluripotent stem cell technology (iPSC) to study psychiatric conditions (such as autism, bipolar disorder, schizophrenia and major depression).; 2) Appreciate the different methods (i.e. single cell transcriptome, and gene editing) used to reveal disease-relevant phenotypes in iPSC-derived neurons and glial cells.; and 3) Understand how different aspects of psychiatric conditions (such as genetic variation and patient response to drugs) can be harnessed to study cellular function in patient-derived neural cells.

SUMMARY:

Many neuropsychiatric disorders are heterogeneous in terms of etiologies, symptoms, disease course, and outcomes. As live human brain tissue is

inaccessible, most autism studies have been restricted to the analysis of post mortem tissues or animal models. While these approaches have yielded important insights, it is clear that there are limitations regarding the transferability of these results to human physiology and psychiatry. The lack of model systems that accurately recapitulate human developmental sequences represents an important obstacle for studying human psychiatric conditions that have genetic and neurodevelopmental etiologies. Induced pluripotent stem cells (iPSCs) are an ideal model system for studying predisposition to psychiatric conditions with complex etiology such as autism, schizophrenia and mood disorders, as they allow researchers to uncover the idiosyncratic developmental deficits that arise from an individual's genetic landscape. In recent years, a variety of stem cell-based model systems have been developed to recapitulate specific aspects of human brain development in a dish, providing an important platform for studying human diseases. The ability to compare live human neurons and glia, be they differentiated from human induced pluripotent stem cells (hiPSCs) or directly induced from patient somatic cells, provides exciting new tools for modeling complex genetic neurological diseases. Members of the panel will discuss novel approaches for comparing global gene expression, neural patterning, maturation, inflammation and synaptic function between neurons and astrocytes derived from neuropsychiatric patients with healthy controls. In doing so, the panel will consider a variety of innovative techniques for generating neural cell types and analyzing cellular phenotypes that are relevant to psychiatric conditions including glial-induced neuroinflammation, single cell transcriptomics, as well as the advantages and limitations of case/control studies and CRISPR-mediated gene editing for isogenic comparisons.

Vulnerable Moms, Vulnerable Babies: Diversity-Informed Approaches to Perinatal and Infant Mental Health

Chair: Laura Beth Kaplan

Presenter: Latoya Comer Frolov, M.D., M.P.H.

Discussant: Elizabeth Lujan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define diversity-informed infant-parent psychotherapy.; 2) Utilize techniques from infant-parent psychotherapy in clinical encounters with vulnerable pregnant and postpartum patients.; 3) Discuss how immigration status, structural racism, and opioid use disorder impact peripartum mental health and infant development.; and 4) Design peripartum mental health interventions that incorporate principles of cultural humility.

SUMMARY:

This session will introduce therapeutic tools for improving maternal and child mental health outcomes in the setting of sociocultural, political, and economic vulnerability. Chronic traumatization—including by prejudice and by poverty – can threaten the emotional wellbeing of the caregiver-child dyad. Women face significantly elevated risk of psychiatric symptoms during pregnancy and the postpartum period, and these risks are amplified by experiences of marginalization. In turn, infants of depressed or anxious mothers have a higher likelihood of insecure attachment and of future psychiatric disorders, and early childhood adversity predicts higher levels of anxiety and of emotional dysregulation. Over the past several decades, psychiatrists have made great strides in recognizing and treating maternal mental illness, but most clinical interventions focus solely on reducing a mother's symptoms with the hope that this may also enable stronger bonding with her baby. In contrast, dyadic interventions can improve attachment between mother and baby, thereby reducing maternal distress and promoting healthy infant development. Presenters will provide an overview of diversity-informed infant-parent psychotherapy. Three clinical scenarios will be described in order to examine the impact of immigration status, institutionalized racism, and opioid use disorder on maternal-infant wellbeing. During small- and large-group discussions about these clinical cases, participants will be invited to strategize about how to incorporate dyadic techniques into routine clinical settings, and presenters will offer additional information about psychotropic medications during pregnancy and breastfeeding and about the impact of maternal psychopathology on an infant's

neurodevelopmental outcomes. Principles of cultural humility and of multidisciplinary teamwork will be emphasized.

What Cultural Assessment Can Contribute to Psychiatric Care in Two Settings: Hurricane Maria in Puerto Rico and Treatment Course in San Diego

Chair: Roberto Lewis-Fernández, M.D.

Presenters: Vanessa Torres Llenza, M.D., Ravi B. Desilva, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss how the CFI can contribute to the evaluation and treatment course of individuals in psychiatric care and to policymaking efforts more generally; 2) Describe how the CFI was used to elicit a person's living situation and access to basic needs and health services after the impact of Hurricane Maria; 3) Describe the impact of information obtained from the CFI on the course of a patient's care as (s)he progresses along a continuum of care services; and 4) Elaborate on the benefits and limitations of the CFI as a tool for eliciting information on the social determinants of an individual's mental health problems

SUMMARY:

Culture affects every aspect of a person's illness experience and process of help-seeking. Information on the impact of culture that is useful for clinical care can be elicited from patients and families directly through a cultural assessment process. The DSM-5 Cultural Formulation Interview (CFI) is a semi-structured instrument for conducting a cultural assessment during a routine clinical evaluation. With the CFI, providers interview patients and/or their relatives about four key domains: the person's and family's cultural definition of the problem; cultural perceptions of cause, context and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking. Research on the CFI shows that patients, their relatives, and clinicians find it feasible, acceptable, and clinically useful. However, to date there is limited information on the impact of the CFI on clinical outcomes, especially in complex systems of care involving team-based treatment. In addition, there are limited data on the extent to which the CFI

sufficiently covers topics related to the social determinants of mental health and structural barriers to needed resources that impact overall health and outcomes of care. This information is not only important to contextualize the help offered to individual patients but also crucial for policy makers developing systemic responses to population needs. In this Cultural Case Conference, Roberto Lewis-Fernández, MD, the lead developer of the CFI, will introduce the instrument. We will then describe its application by presenting cases from two very different settings. The first case illustrates how the CFI can help assess a person's living situation and access to basic needs and health services after the impact of Hurricane Maria, which devastated Puerto Rico on September 20, 2017. The case will be presented by Vanessa Torres-Llenza, MD, one of the founders of Crear Con Salud, a psychiatrist-run organization that supports community-based efforts to enhance mental health in Puerto Rico and Latino/a communities in the United States. The second case describes the impact of information obtained from the CFI on the course of a patient's care as (s)he progresses from a psychiatric emergency department to inpatient and outpatient services in a military mental health setting. This case will be presented by Ravi DeSilva, MD, a contributor to the development of the CFI, who is a Lieutenant Commander in the US Navy Reserve and Staff Psychiatrist at Naval Medical Center San Diego. Time will be devoted to interaction with the audience throughout the presentation. At the conclusion of the case conference, participants will be better able to appreciate the contribution that the CFI can make to the evaluation and treatment course of individuals in psychiatric care and to policymaking efforts more generally.

What We Know and Don't Know About Asian-American Mental Health

Presenter: Stanley Sue

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review research findings on the rate and distribution of mental disorders among Asian Americans; 2) Identify cultural factors that affect the validity of mental health assessments; 3) Recognize the cultural issues that affect the

utilization and mental health services; and 4) Create and utilize cultural strategies in the treatment of Asian Americans

SUMMARY:

This presentation addresses the mental health and psychotherapeutic treatment of various Asian groups (Chinese, Japanese, Koreans, Vietnamese, and others) in the United States. Several points are made. First, it appears that the rate and distribution of mental disorders among Asian Americans have been underestimated. Although epidemiological surveys reveal lower prevalence rates of mental illness among Asian Americans, Asian Americans have significant risk factors for mental health problems. For example, Asian Americans are largely comprised of immigrants or refugees who have limited English proficiency. As a minority group, many have experienced stressors involving stereotypes, prejudice, and discrimination. Survey results may be misleading because of the diversity of Asian Americans, diagnostic system used, and possible culture-specific forms of disorders. When these limitations are considered, there is evidence that prevalence rates have been underestimated. Discussed are the strategies needed in making culturally valid assessment and in the identification of cultural biases in symptom reporting. A focus on prevalence in Asian Americans as a whole also shrouds important subgroup elevations such as heightened suicide risk in Asian elderly women or greater posttraumatic stress disorder in Southeast Asian refugees. Second, Asian Americans underutilize mental health services. This underutilization occurs regardless of the particular Asian ethnic group involved, although level of acculturation is directly related to rate of utilization. Explanations for this underutilization are reviewed: Shame and stigma over mental illness, presence of alternative services, cultural differences in conceptualizations of mental health, and limited accessibility and availability of bilingual and bicultural services. Systematic efforts deal with these issues or to overcome these problems have led to increase service use. Third, this presentation critically examines the progress of cultural adaptations of psychotherapeutic treatments for Asian Americans. These adaptations include the integration of culturally consistent language,

concepts, and problem-solving strategies into treatment. According to several meta-analyses of treatment outcome research, if these cultural adaptations are incorporated into treatment protocols, Asian Americans (as well as other ethnic groups) exhibit better treatment outcomes. The availability of culturally-adapted services for Asian Americans is crucial. In addition, In order to reduce mental health care disparities, greater efforts are needed to provide outreach at the community level and to bridge the gap between mental health and other medical or alternative health facilities.

Who's in Charge? Medications for Addiction Treatment and the Criminal Justice System

Chair: Sherry Ann Nykiel, M.D.

Presenters: Pooja P. Shah, M.D., Joseph Esposito, M.D.

Discussant: Clarence Watson, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) By the end of the session, participants will identify three benefits of providing MAT in the criminal justice system.; 2) By the end of the session, participants will list three barriers to the implementation of MAT programs in the criminal justice system; and 3) By the end of the session, participants will describe one concrete action that can be taken to advocate for the use of MAT in the criminal justice system.

SUMMARY:

People with substance use disorders are overrepresented in the criminal justice system (CJS). A 2017 special report published by the U.S. Department of Justice estimates that more than half of all incarcerated Americans meet criteria for a substance use disorder (SUD), yet only about 10% receive any substance abuse treatment. Despite the clear evidence supporting the use of medications for addiction treatment (MAT), its adoption in the criminal justice system remains controversial. Barriers to more widespread use include logistical, financial, and perhaps most importantly, deeply engrained attitudes regarding MAT. Implementation of and attitudes towards MAT vary widely throughout the country and clinicians must be aware of their local jurisdiction's policies to better serve

their patients. Finally, in areas where the criminal justice systems fails to provide effective, evidenced based treatment, clinicians must be on the front line advocating for policy change. This workshop will review the current state of substance abuse treatment in the CJS, including the abundance of evidence supporting the use of MAT. In particular, it will focus on the negative consequences associated with the underutilization of MAT for opioid use disorders. Participation in the workshop will increase clinicians' awareness of these issues in general, enhance clinical decision-making, and motivate clinicians towards public advocacy. Participants will have the opportunity to work in small groups to identify specific strategies that can be used to advocate for the use of MAT and other evidenced based treatments in this marginalized and often overlooked population.

Why Do House Staff Sometimes Act Like Borderlines? Or Momma Never Said There Would Be Days Like This!

Chair: Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the use of "borderline" defenses in medical personnel who do not have borderline personality disorder; 2) Explore the abusive impact of medical training that influences the use of primitive defenses by medical personnel; and 3) Learn methods of ameliorating the impact of projective identification in the medical setting

SUMMARY:

In projective identification (PI) parts of the self and internal objects are split off and projected another person, who then becomes possessed by, controlled and identified with the projected parts. This is an unconscious process but the impact on the "other" is dramatic and distressing. The concept has proven useful in the work with patients, particularly patients with borderline personality disorder, since its creation in 1946. Though rarely discussed, PI occurs in a variety of situations, some positive and some negative, and is a psychological operation not exclusively used by borderlines. This workshop will target situations encountered by C-L psychiatrists,

focusing on interactions with consultees and colleagues. The workshop will discuss the mechanism and its utility across the spectrum from primitive personality disorders to everyday life. It will detail the moment-by-moment interpersonal interactions that create projective identification, and discuss ways of dealing with the intense emotions created by the experience of PI. The interactive portion of the workshop will be devoted to practical situations where PI occurs, focusing on two common occurrences: A consultee accusing a consultant “you’re the problem here” when dealing with a difficult patient situation; and a faculty member engaging in projective identification such that the other person feels inadequate and demoralized. We will engage ourselves in experiencing projective identification and in finding creative ways to handle the situations.

Yes...There’s an App for That—but What Do Clinicians Need to Know?

Chair: Andrew David Carlo, M.D.

Presenters: Reza Hosseini Ghomi, M.D., Brenna Renn

Discussant: Steven Richard Chan, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current mHealth app environment as it pertains to mental health; 2) Identify three of the existing frameworks that are used to rate and review mobile mental health apps and understand which apps have scored highly and why; 3) Understand at least three challenges associated with scoring or rating mobile mental health apps and identify some consequences of the current lack of standardized methods; 4) Identify which mobile mental health apps are most downloaded and used by consumers and some of the possible explanations for these findings; and 5) Identify which mobile mental health features and qualities are most relevant to clinicians and consumers and understand how to discuss these with patients

SUMMARY:

In recent years, the development of digital health applications (often termed “mHealth apps” (Aitken & Lyle, 2015)) has paralleled the explosive growth in smartphone and mobile technology. The latest

estimates suggest that between 165,000 and 325,000 health care and wellness applications (Aitken & Lyle, 2015; Neary & Schueller, 2018; Pohl, 2017; John B. Torous, Chan, Yellowlees, & Boland, 2016) are now directly available to patients, with 78,000 new additions between 2016 and 2017 and a year-over-year growth rate of twenty-five percent (Pohl, 2017). Furthermore, one study estimated that in 2015, twenty-nine percent of disease- or condition-specific applications were designed primarily for mental and behavioral health disorders, the highest of any illness category (Aitken & Lyle, 2015). Few of these mHealth apps across a variety of psychiatric disorders have been validated in randomized controlled trials (Kuester, Niemeyer, & Knaevelsrud, 2016; Mohr, Weingardt, Reddy, & Schueller, 2017; Richards & Richardson, 2012)). Additionally, few studies have substantiated the effectiveness of these apps in usual treatment settings (Gilbody et al., 2015; Mohr et al., 2017). Consequently, providers and patients are left recommending and choosing mHealth applications in an increasingly complex, crowded, and poorly studied marketplace. In response, a number of evaluation tools (American Psychiatric Association, 2018; Baumel, Faber, Mathur, Kane, & Muench, 2017; Neary & Schueller, 2018; Schueller, 2018; J. Torous et al., 2018; John Blake Torous et al., 2018) have been proposed to objectively rate or score mental health applications across a variety of dimensions, including security/privacy, evidence base, ease of use, and interoperability. However, to date, there is no universally accepted evaluation method or tool (National Institute of Mental Health, 2017). We are not aware of any measure of penetration of these frameworks into user decision-making, nor if these frameworks align with user needs. As a result, mHealth application purchasing and downloading decisions are often made using heuristics that compel the consumer to quickly weigh easy-to-identify metrics or attributes such as title, logo, price, rankings and ratings (Huang & Bashir, 2017). The results are perhaps unsurprising – even in organized clinical trials, patients tend to use mHealth apps for no more than two weeks without clinician involvement (Areal et al., 2016; Baumel & Yom-Tov, 2018; Kohl, Crutzen, & De Vries, 2013; Lee et al., 2014; Rosa, Campbell, Miele, Brunner, & Winstanley, 2015). Outside of these studies,

longitudinal usage is likely even more improbable. To explore these issues more deeply, the authors will present on several publicly available app evaluation frameworks, including the American Psychiatric Association's model. We will present "real-world" user data to demonstrate the extent to which these frameworks align with market trends and where gaps exist. We will also share results of qualitative research identifying factors that play important roles for users when choosing an app. Finally, we will present a potential strategy for mHealth app evaluation that could be more effective and sustainable than existing methods.

Learning Labs

Saturday, May 18, 2019

Ethics in Real Time: Learning Through Simulation

Chair: Rebecca W. Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn various theories, frameworks, and approaches to making ethical decisions in simulated cases; 2) Appreciate the contributions of theory, method, science, and social science to moral judgment; and 3) Develop skills and strategies to identify and engage ethical challenges that arise in medical practice

SUMMARY:

Psychiatric ethics requires knowledge of theory, frameworks, and approaches to ethics as well as development of skills to practically engage challenges in research and practice. In this innovative learning lab session, teams of participants will function as ethics committees to make a series of decisions with broad ethical (and at times life and death) consequences. This dynamic simulation will push participants to state their positions and then unpack the reasoning and other factors that contributed to their individual and group positions. The three-hour activity will be divided into two roughly equal sections: first, the interactive group activity, and second, a focused debrief eliciting participant self-reflection as well as didactic engagement of participant perspective and fundamental theory and perspectives on ethics and moral decision-making. Specifically, participants will

come to understand major philosophical approaches to ethics, as well as critiques and frameworks addressing narrative, gender, race, and disparities (social determinants). In addition, the didactic portion will engage contemporary neuro and social science research on moral decision-making to inform and deepen appreciation of the complexity of ethical inquiry and application in psychiatry. Due to the interactive and participatory nature of this activity, full participation from each participant is necessary for the group learning experience. Therefore, participants will be asked to stay for the entirety of the session.

Sunday, May 19, 2019

"Hearing Voices That Are Distressing" Simulation

Chair: Mary Kay Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain how "hearing voices" differs from "auditory hallucinations"; 2) Discuss the emotional and cognitive impacts, if any, caused by hearing voices during the simulation exercise; 3) Identify three specific changes to be incorporated into an initial diagnostic assessment when psychosis is suspected; and 4) Discuss three coping strategies to consider sharing with individuals who hear voices that are distressing

SUMMARY:

Attendees should plan to bring headphones that connect to their mobile devices to this session. Attendees must stay for the full session.

Co-Responder Crisis Response Model: Crisis Assessment, Intervention, and Field Tactics

Presenters: Mario Molina, Anton Nigusse Bland, M.D., Christopher M. Weaver, Ph.D., Elizabeth Prillinger

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Identify barriers to care, including health service

delivery issues; and 4) Integrate knowledge of current psychiatry into discussions with patients

SUMMARY:

This learning lab session is a full simulation experience which will allow attendees to practice their response to a crisis scenario, discuss why someone would come to a crisis stabilization center, highlight programs and clinical approaches, and discuss experiences clinicians and law enforcement encounter serving in San Francisco. This activity is designed to be developmental and will focus on crisis management, communication, implicit bias, stigma and the importance of emergency preparedness. Attendees can expect engaging didactic presentations, experience simulation, as well as group discussion. Attendees should also be aware of the use of simulated weapons during this session. Please note these simulated weapons resemble actual weapons but are not capable of use as a weapon.

Intern Year—The Board Game: An Educational Experience for Learning About Physician Wellness, Burnout, and Depression

Chair: David A. Ross, M.D., Ph.D.

Presenters: Ashley E. Walker, M.D., Melissa Arbuckle, M.D., Ph.D., Joseph J. Cooper, M.D., Manesh M. Gopaldas, M.D., Andrew Michael Novick, M.D., Ph.D., Elise Stephenson Scott, M.D., Desiree Nicolette Shapiro, M.D., Maja Skikic, M.D., Michael John Travis, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of burnout and depression in interns; 2) Describe key risk factors for developing burnout and depression; 3) Describe core principles and strategies for resilience; and 4) Have access to comprehensive resources for learning about wellness, burnout, and depression and for developing new initiatives in their program

SUMMARY:

One of the most critical and high-profile issues in medicine today is physician burnout. The media is saturated with stories of doctors' struggles with the ever-evolving healthcare environment, including

increased financial pressures (sacrificing perceived quality of patient care for faster and increased numbers of patient encounters), difficulties with EMR systems, and broad structural concerns (including decreased access to care and decreased social services for the most vulnerable populations). Clinicians struggle with these issues almost immediately in their training. For example, studies have shown that interns have a point prevalence of depression of 25% and a cumulative prevalence of 40-50% over the year.¹ Even more disturbingly, up to 20% of interns may experience suicidality during the course of the year.² Tragically, these numbers translate into physicians having twice the risk for completed suicide.³ It is time for a broad dialogue about the causes of physician burnout and depression and to come together as a community to identify and implement potential solutions. As educators, we know that traditional, lecture-based approaches may be limited in their ability to effect change. The art of teaching is about finding ways to bring content to life through experiential learning exercises. In this session we will introduce participants to Intern Year — a cooperative board game designed by the National Neuroscience Curriculum Initiative to facilitate crucial, and often challenging, conversations about physician wellness and depression. We will then reflect with the group on the process of creating and implementing an Educational Game for teaching and learning in medicine.

Monday, May 20, 2019

Assisted Suicide or Assisted Dying? A Debate

Moderators: Ron M. Winchel, M.D., Joel Asher Bernanke, M.D., M.Sc.

Presenters: Mark Stephen Komrad, M.D., David Alan Pollack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the legal/regulatory terrain governing physician-assisted death in various jurisdictions; 2) Understand considerations regarding role of psychiatrists in determinations of competency and depression in medical patients who are seeking PAS; 3) Understand arguments regarding the possibility that

allowing PAS may start to lower the threshold for assisted death; 4) Understand arguments about the inherent morality of doctors participating in the hastening of death; and 5) Understand the experience thus far in jurisdictions that have legal access to physician-assisted death

SUMMARY:

Inherent to our identity as physicians, is our implicit dedication to the preservation of healthy life. Equally inherent, however, is our inevitable confrontation with pain and mortality. At the nexus of these two necessary conditions of our professional selves, lies a conundrum that has increasingly become the focus of ongoing debates in the world of medicine, ethics, philosophy, and law: is there an appropriate role for the physician when a patient wants to choose to end their pain at the expense of their life? Is this physician-abetted suicide or is it the last act of a doctor easing the pain of their patient? Is such an act an extension of medical care or is it contrary to the very nature of medicine? In a handful of American states and European countries physician assistance is now legally available within the constraints of a variety of laws and regulations. As psychiatrists we would not seem to be as likely as other physicians to find ourselves on the front lines of this dilemma. But that may just be a comforting illusion that allows us to escape a morally perplexing question. The associated questions of competency, depression and the suicidality draw us in. There is the murky problem of whether some psychiatric cases can ever be considered absolutely untreatable and unremittingly painful – raising the question of whether or not psychiatric illness may be included as a consideration for physician-assisted death in legal jurisdictions. Other questions abound. Is the ethical tradition of medicine inextricably bound to the avoidance of facilitated death? Do we deny the autonomy of human beings if we feel this choice is off-limits? Are we sticking our heads in existential sand when we decline to use a tool that can end unremitting pain? And since history teaches us that genies do not like to remain in their bottles, might we be opening a path down a slippery slope where moral constraints might weaken, despite efforts at regulatory control? At the end of the debate audience members will be able to present questions to the debaters.

Medical History Mystery Lab

Presenters: Kenneth Bryan Ashley, M.D., Daena L. Petersen, M.D., M.A., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use medical decision-making and problem-solving skills to solve a complex medical case; 2) Work collaborative to determine the complicated medical history of a patient; 3) Critically reflect on topics such as diagnosis, treatment, medical ethics and integrated care; and 4) Examine the role that mental health and psychiatry plays in patient care

SUMMARY:

The Medical History Mystery Lab (MHML) is a medical education learning format that employs game-based learning and mechanics. MHML allows for high-level engagement and dynamic group discussion as participants work collaboratively to determine the medical history of a particular patient.

Tuesday, May 21, 2019

A Leadership Boot Camp for Residents and Fellows

Presenters: Ashley E. Walker, M.D., Sandra M. DeJong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Integrate knowledge of current psychiatry into discussions with patients; and 4) Identify barriers to care, including health service delivery issues

SUMMARY:

Being a great leader in psychiatry today requires more than just great clinical acumen. Many of the skills currently needed for successful leadership fall outside the standard residency or fellowship training curriculum. This annual boot camp aims to teach core skills in effective leadership in a fun, interactive setting. In this year's session, Drs. DeJong and Walker will focus on understanding the difference

between leadership and management, finding your calling, time management and improving efficiency, and leading in a multicultural world to enhance diversity, equity, and inclusion.

You Are Human: Addressing Burnout Through Improv

Chair: Ashley Whitehurst

Presenter: Tristan Gorrindo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify major factors leading to burnout; 2) Understand the balance of physician needs and patient needs; 3) Utilize techniques from improv to combat burnout through better communication, self care, and personal connection; and 4) Let go and have a little fun

SUMMARY:

Beep Bop Boop, guess what? You are not a robot that is expected to endure the same task over and over or expend all of your energy without release, recovery, and relaxation. Professional burnout can impact physicians' health, quality of life, quality of care they provide, and their productivity. There is substantial evidence of burnout and vulnerability among psychiatrists. The helpers and healers who treat those who need help are becoming more isolated, burnt out, and, more than ever, are at an increased risk of depersonalization, depression, and suicide. What can we do to address this alarming trend and bring wellness to psychiatrists? Improv. Improv? Yes! Improv! By applying the basic fundamentals of improv, we can move from isolation to more connection. We will learn to drop our barriers and guards and be comfortable with doing so. We will take care of ourselves so that we're better equipped to take care of others. Using basic improv techniques allows every individual to overcome self judgement, drop pre-conceived notions to serve the situation/circumstances and not our own agenda, and be more comfortable about collaboration, communication, and connection with others.

Wednesday, May 22, 2019

Prospective Memory and Planning: A Virtual Reality Game for Patients With Schizophrenia

Chair: Isabelle Reine Amado

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) explain the virtual reality tool; 2) explain what is cognitive remediation; 3) present a research methodology; 4) demonstrate how virtual reality could be used for prospective memory; and 5) present innovative tools for therapy in schizophrenia

SUMMARY:

Cognitive deficits in schizophrenia have huge consequences in everyday functioning. Patients complain difficulties in instrumental daily living. These disabilities to perform daily activities have an incidence on their need for care and can be partly responsible for chronicity and institutionalization in therapeutic activities. We present here a virtual reality game where patients with schizophrenia perform during a three-months group a virtual reality (VR) game in a virtual town. Ten patients attend to 15 weekly one hour and a half sessions organized by a nurse and a psychologist. During the 2 first sessions they have to list together all the difficulties they experience in organizing and plan their daily activities. After being familiarized with the joystick and the VR environment, participants have to select an area, to navigate in the town, and solve complex everyday problems mimicking their usual life, following the frames elaborated by the two caregivers (e.g: shopping but taking money in the cash box before, not forgetting to fetch a friend at the station, memorizing an itinerary to go to the supermarket, being on time in a meeting point with friends). They have to elaborate different alternative itineraries, and practice a switch from a 2D-Map to the 3D-Map. When a participant plays with the joystick, the others help him and share strategies. A pilot study in a small sample of chronic patients with schizophrenia, who visited for years a day-care hospital showed significant benefits in attention, working memory and ability to sequence actions in prospective memory. Patients also experienced a clinical and functional improvement with for some of them a strong energy to elaborate concrete plans to search for jobs or return to activities in the community. Qualitative assessments reported a gain

of time during the day, better planning, enrichment in relatedness, more management of their homework with high scores in a satisfaction questionnaire. This VR game opens avenue for cognitive remediation and rehabilitation more adapted to chronic patients, and could be a stepping stone for making new project, for less attendance in day care units and a better community living.

Master Courses

Saturday, May 18, 2019

Buprenorphine and Office-Based Treatment of Opioid Use Disorder

Director: Petros Levounis, M.D.

Faculty: John A. Renner, M.D., Andrew John Saxon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder; 2) Apply the pharmacological characteristics of opioids in clinical practice; 3) Describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; 4) Describe the legislative and regulatory requirements of office-based opioid pharmacotherapy; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain

SUMMARY:

This course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD) and review 1) *DSM-5* criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality rules related to treatment of substance use disorders; 3) Drug Enforcement Administration requirements for recordkeeping; 4) billing and common office procedures; 5) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, and ADHD and how to distinguish independent disorders from substance-induced psychiatric disorders; and 6) common clinical events associated with addictive

behavior. Special treatment populations, including adolescents; pregnant addicts; and geriatric, HIV-positive, and chronic pain patients, will be addressed, and small-group case discussions will be used to reinforce learning.

Sunday, May 19, 2019

Update on Pediatric Psychopharmacology

Director: Karen Dineen Wagner, M.D., Ph.D.

Faculty: Christopher John McDougale, M.D., John T. Walkup, M.D., Steven Ray Pliszka, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders; 2) Identify practical knowledge gained in the use of psychopharmacology and management of adverse effects; and 3) Utilize recent research on pharmacotherapy in common psychiatric disorders of childhood

SUMMARY:

The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents. This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorder. The role of pharmacotherapy in the treatment of these disorders will be addressed, as will practical clinical aspects of using psychotropic medications in the treatment of children and adolescents. Management of adverse effects will be reviewed as well. Awareness of recent research data will help to facilitate an understanding of the basis for current clinical guidelines for the treatment of these psychiatric disorders. Clinically relevant research will be reviewed, within the context of clinical treatment. Awareness of recent research and clinical guidelines on the use of pediatric psychopharmacology, and the application of this information to clinical practice, can inform and positively impact patient care.

Monday, May 20, 2019

Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice

Directors: Richard A. Bermudes, M.D., Philip G. Janicak, M.D.

Faculty: Karl I. Lanocha, M.D., Ian A. Cook, M.D., Steven Ryan Vidrine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the mechanism of action of TMS; 2) Identify appropriate patients for TMS; 3) Understand the efficacy of TMS for the treatment of major depression, OCD, and other psychiatric disorders; 4) Identify the risks and side effects of TMS; and 5) Review the specifications of FDA-cleared TMS systems

SUMMARY:

Psychiatric disorders represent a significant and growing problem for society. While many patients are effectively treated with pharmacotherapy, psychotherapy, or a combination of the two, up to 30% with mood and anxiety conditions do not respond to these standard treatments. In October 2008, the first transcranial magnetic stimulation (TMS) system was cleared by the U.S. Food and Drug Administration (FDA) for the treatment of adult patients with major depression who had not responded to one antidepressant medication. This marked the beginning of one of the most innovative and disruptive treatment developments for psychiatry in the last decade. TMS allows the psychiatrist to modulate specific neural networks that affect mood, thinking, and behavior. In 2018, the first TMS system was cleared by the FDA for the treatment of patients with OCD who have not responded to medication and psychotherapy. Now, patients have access to this groundbreaking form of neuromodulation at numerous centers in the United States, and there is broadening clinical applications into other psychiatric conditions as well as expansion in insurance coverage. Despite the growing availability of this innovative option, many psychiatrists are unsure about how to best utilize TMS. This course provides practitioners with practical information for the management of patients who are candidates for TMS therapy. The

course speakers are clinician-researchers with extensive knowledge about the clinical applications of TMS, as well as other forms of neuromodulation. The course reviews TMS mechanism of action, applications for depressed patients and other psychiatric conditions, patient selection for the TMS, as well as a thorough review of the current FDA-cleared TMS therapy systems. Teaching techniques will include didactics, case discussion, and panel discussion. Each attendee will receive a copy of *Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice*. In summary, this course provides both an update on the present clinical role of TMS and a road map to its potential future.

Tuesday, May 21, 2019

Essentials of Clinical Psychopharmacology

Directors: Alan F. Schatzberg, M.D., Charles DeBattista, M.D.

Faculty: Michael J. Ostacher, M.D., M.P.H., Manpreet Singh, M.D., Rona Hu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an update on major classes of psychopharmacological agents; 2) Review recent data on drugs under development—both positive and negative data; 3) Provide a framework for integrating multiple modalities of treatment; and 4) Review recent data on devices to treat major disorders

SUMMARY:

Psychopharmacology continues to expand in options for a variety of disorders. This course, which has presented for several years will provide a review of recent studies and experience on key classes of agents to treat specific common psychiatric disorders. The course will present data on antidepressants under development, the use of brain stimulation devices to treat depression and anxiety disorders, treatment of bipolar disorder, antipsychotic agents for schizophrenic patients, treatment of childhood disorders, and the management of insomnia. The presentations will be preceded by an audience participation set of test questions to assess knowledge base. After each

presentation, there will be approximately 10 minutes for audience questions and answers. The last hour will include breakout sessions with a number of the primary presenters to discuss clinical cases. The course provides a vehicle for maintenance of certification credits. All participants will receive the latest edition of the *Manual of Clinical Psychopharmacology*.

Wednesday, May 22, 2019

Psychodynamic Therapy for Personality Pathology: Transference-Focused Psychotherapy—Extended

Director: Eve Caligor, M.D.

Faculty: John Clarkin, Ph.D., Richard G. Hersh, M.D., Otto F. Kernberg, M.D., Frank Elton Yeomans, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply recent developments in our understanding and classification of personality disorders to clinical practice; 2) Perform clinically meaningful assessment of personality functioning and pathology; 3) Understand the general clinical principles organizing psychodynamic therapy of personality disorders; 4) Establish a treatment frame and contract with patients presenting with personality pathology at different levels of severity; and 5) Understand the role of countertransference management in the treatment of patients with personality pathology at different levels of severity

SUMMARY:

Recent developments in our understanding of personality disorders emphasize the centrality of self and interpersonal functioning across personality disorders, with severity of impairment in self and interpersonal functioning emerging as a robust predictor of course and outcome. This course will provide an overview of Transference-Focused Psychotherapy—Extended (TFP-E), a transdiagnostic psychodynamic treatment package for personality disorders emerging from this dimensional model of personality pathology. The one-day curriculum will begin with an introduction to the object relations theory model of personality disorders underlying the treatment, followed by an overview of the treatment model. Presentations will then focus on the clinical

objectives and core techniques that define TFP-E, emphasizing how techniques are modified according to severity of personality pathology. In addition to focusing on specific elements of technique, the course will highlight their general clinical utility and accessibility for export to shorter-term, symptom-oriented treatments and acute treatment settings.

Media Sessions

Saturday, May 18, 2019

Crazy (Not Always Rich) Asians: The Impact of Culture on Mental Health Needs and Care Utilization

Chairs: Eun Kyung Joanne Lee, M.D., M.S., Stephanie Han, M.D.

Presenter: Rona Hu, M.D.

Discussant: Edmond H. Pi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore aspects of Korean history and culture - oftentimes shared by other Asian countries - that impact mental health needs and stigma.; 2) Identify barriers to seeking and utilizing mental health resources in Asian population, including differences in acculturation and identity between the various generations of immigrant populations.; 3) Critically analyze media depictions of Koreans and other Asian immigrants, and subsequent generations, to gain a better understanding of the existing stereotypes and implicit biases.; and 4) Develop creative, innovative methods to reach the Korean American community in a culturally sensitive manner.

SUMMARY:

According to the 2010 U.S. Census, Asian Americans comprise 5.6% of the U.S. population, a large growth from less than 0.5%, per the 1960 Census. The passage of the Immigration and Nationality Act Amendments in 1965 sparked the largest wave of Korean immigration to the U.S., and the Korean American population has since burgeoned to the fifth-largest Asian American subgroup. Studies have shown Korean Americans have high rates of mental health problems but low rates of service utilization, and cultural factors have often been cited as central to the stigma surrounding mental illness. Though

there are unique aspects of Korean American culture that shape its people's needs and service utilization patterns, there are also broader themes that resonate with other Asian American populations. In this interactive session, we will use excerpts from award-winning Korean films and the globally popular Korean television broadcasts often referred to as "K-dramas," as well as depictions of Asian immigrant families in Western media, to identify and demonstrate cultural values, biases, popular stereotypes, and barriers to recognizing mental health needs and accessing services in the Asian American community. Through case vignettes, we will highlight differences in acculturation and identity between the various generations of immigrant populations. Finally, we will together generate creative, innovative methods to engage and partner with the Asian American community to address its needs. This media session will be high yield for clinicians at the APA who are interested in expanding not only their knowledge of Asian American mental health (and in particular, Korean American mental health), but also their professional network, as we together discuss and explore mental health disparities in immigrant communities.

Hip-Hop: Cultural Touchstone, Social Commentary, Therapeutic Expression, and Poetic Intervention

Chair: Sarah Yvonne Vinson, M.D.

Presenters: Christopher James Hoffman, M.D., Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relevance of hip-hop as an art form in American culture.; 2) Describe how the medium has been used as a coping mechanism; 3) Identify ways in which mainstream hip-hop artists have leveraged their notoriety for social commentary.; and 4) Discuss hip hop's role in social intervention.

SUMMARY:

The iconic Pulitzer Prize is a gold medal award for achievements in American journalism, literature, and music. Winners include John F. Kennedy, Robert Frost, Alice Walker, and Thomas "Tennessee" Williams. In 2018, Kendrick Lamar joined the ranks of distinguished Pulitzer Prize winners in music for

"DAMN," making him not only the first rapper ever to win the music award but the first winner who is not a classical or jazz musician. Hip-Hop is mainstream now but has its origins as an artistic expression for marginalized populations. Their lyrical content and imagery provide a lens into a medium that has been used to cope with trauma and destigmatize discussions about mental health. Its dominance in pop and music culture, particularly for millennials and Generation Y, make it a worthy topic of discussion as the messages and commentaries reach a broad swath of an important audience. Music videos are also an indicator of how artists are leveraging the platform to make commentaries on aspects of American culture with significant implications for mental well-being such as substance use, racism, poverty, and patriarchy. A sample of the videos discussed will be "All the Stars" and "Alright" by Kendrick Lamar, "Formation" by Beyonce, "Nice for What" by Drake, "XO Tour Life" by Lil Uzi Vert, "This is America" by Childish Gambino, "Glory" by Common and John Legend, and "Change" by J. Cole.

Lost Boys of Sudan: Immigration as an Escape Route for Survival—Understanding the Challenges of Political Immigration Through the Eyes of Two Boys

Chairs: Dilys Ngu, M.D., Samuel Osifo Okpaku, M.D., Ph.D.

Presenters: Shridhar Sharma, M.D., Jayaprabha Vijaykumar Nair, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the challenges of immigration/ Emigration trauma and challenges with acculturation; 2) Explore the impact of pre immigration trauma on individuals who have endured political trauma; 3) Learn the effects of current views, atmosphere on immigrants and asylum seekers in individuals and their families who came as refugees and immigrants.; 4) Identify and provide support following best practices that intervene for immigrants as well as refugees who faced political trauma; and 5) Understand the loyalty dynamics of immigrants and refugees with regards to giving back to their countries of origin and their country of adoption, in the case, the USA

SUMMARY:

The Lost Boys of Sudan was the name given to a group of over 40,000 boys of the Nuer and Dinka ethnic groups. These boys were displaced or orphaned during the Second Sudanese Civil War (1987–2005) in which about 2 million Sudanese were killed and millions of others were severely affected. The name "Lost Boys of Sudan" was colloquially used by aid workers in the refugee camps where the boys resided in Africa. The boys embarked on treacherous journeys to refugee camps in Ethiopia where they were sheltered for a few years. Soon, official resettlement programs began throughout the US. The Lost Boys were offered new lives in major US cities. The Sudanese conflict, which incited the journey of the Lost Boys, stemmed from divisions among the Northerners and Southerners. Following Sudan's independence from Britain in 1956, these divisions became contentious. The northern region of the country was primarily Muslim, which contrasted ideologically with the Christian and animist religions that were more prevalent in the south. Religion played a crucial role in this conflict because British Christian missionaries were welcomed in the South, yet the North wanted a homogenous nation of Muslims. During the Second Sudanese Civil War, children were unable to adequately support themselves and suffered greatly from the terror. Many children were orphaned or separated from their families because of the systematic attacks in the southern part of the country. Some children were able to avoid capture or death because they were away from their villages tending to cattle at the cattle camps. Cattle camps refers to grazing land located near bodies of water where cattle were taken and tended largely by the village children during the dry season. As a result of being away from the villages, the boys were able to flee and hide in the dense African bush before being captured. Some of the unaccompanied male minors were conscripted by the Southern rebel forces and used as soldiers in the rebel army, while others were handed over to the government by their own families to ensure protection, for food, and under a false impression the child would be attending school. Children were highly marginalized during this period. Resultantly, they began to conglomerate and organize themselves in an effort to flee the country and the war. After showing the docudrama the presenters will focus on 3 major areas 1. The journey

of the boys: Pre immigration trauma, immigration/emigration, the stresses, elation, acceptance, and settlement 2. Acculturation: Due to cross national, cross cultural, cross racial dynamics and how they coped with the issues to become overcomers 3. The loyalties to the country and people of origin and the nation, people that provided them a new life, hope, optimism, belief in self and others. Lastly, various cross national, cross racial issues during this journey from Africa to USA will be discussed. Special emphasis will be given to the impact of present socio-political atmosphere on the immigrants, refugees and asylum seekers with their families.

Sunday, May 19, 2019

Learning About Psychiatric Disorders Through a Theater Presentation: Under the Dragon

Chair: Carol Wendy Berman, M.D.

Presenters: Jose P. Vito, M.D., David W. Brody, M.D., Asha D. Martin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how bipolar disorder impacts the person's life; 2) Describe some of the symptoms of schizoaffective disorder; 3) Understand how OCD and workaholic habits coincide; 4) Entertain the audience while they learn about psychiatric disorders; and 5) Explore boundary violations in clinical practice

SUMMARY:

We will present the film of a play written by a psychiatrist, Carol W. Berman, M.D. The play was produced at the Neighborhood Playhouse. Dr. Berman has full rights to the play and the film. In this play a psychiatrist with bipolar disorder interacts with her attorney husband who has OCD and workaholicism. Dr. Greene, the protagonist psychiatrist, is stalked by her patient, Peter, who has schizoaffective disorder. She has a manic episode and imagines that she has an affair with her patient and that he consequently commits suicide. Fortunately, it was all in her imagination and these issues are resolved with a positive outcome. We will run the film of the play, which we will stop at

intervals to discuss the different disorders as well as the ethics of a psychiatrist getting involved with her patients.

When All That's Left Is Love

Chairs: Eric Gordon, Ruby C. Castilla Puentes, M.D.

Presenters: Fernando Espi Forcen, M.D., Ph.D.,

Tatiana A. Falcone, M.D., Carolina Remedi

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To describe the impact of caregiving on the mental health of caregivers; 2) To review avenues for supporting caregivers of patients with AD and other dementias; 3) To examine different coping strategies which are used at different stages of caregiving; and 4) To describe ways to reduce frustrations and barriers in the caregiving experience

SUMMARY:

When All That's Left is Love is unique in that it is the only known contemporary film about Alzheimer's that bravely presents the difficult inside story of the caregivers' journey, as viewed by a son. While there are many films about Alzheimer's patients and their disease, Eric Gordon's story focuses on his mother Marilyn and a neighbor, Arline Rothman, as they struggle to care at home for spouses who are living with moderate to severe stages of Alzheimer's disease. Gordon shows us the other side of Alzheimer's: the lives of caregivers who are courageous and worthy, yet utterly human, individuals who – out of love – have taken on the most overwhelming role of their lives. Although they long to offer their loved ones the best care possible, the constant needs, and changing behaviors of the patient often make that impossible. They live with guilt and a sense of having failed at a nearly impossible task. Marilyn tells her son: "It's hard to see some-one you love deteriorate the way he did." The filmmaker's mother Marilyn – on duty 24/7, feeling as trapped as her husband is – has entered a state of near collapse, both physical and emotional. Nothing has prepared her for managing her husband's difficult and ever-changing behaviors; his inability to toilet, bathe, move around, and eat without her constant monitoring. She must guard constantly against Shelly escaping out the door,

barefoot, no pants, all while trying to find 20 minutes to rest. But Shelly cannot bear being away from her - not for a minute. When the exhausted Marilyn tries to nap, Shelly insists on crawling onto the bed beside her. The couple's closeness is still quite beautiful, even when difficult to watch. The emotionally-taut scenes reveal the sense of a long-married couple's everyday life, sometimes turned on its head. After 62 years of her own wonderful marriage, neighbor Arline Rothman's life revolves around the hope that her husband, Hy, will have a moment of clarity and know that his wife is there supporting him and giving him love. In a more advanced stage of the disease than Shelly is, Hy is living in a nursing home and in the final stages of this disease. Dr. C. Williams tells Gordon about the many misunderstandings about the disease. "Some people say: 'This person isn't even a person anymore. There's no need to visit him.' They don't realize that the essence of the person does not go away. You can develop meaningful relationships with someone at that late stage of dementia. And it does make a difference to the person with dementia if the caregiver comes in to visit." Many scenes in the film reveal the proof of that statement. Following film presentation a diverse panel of psychiatrists (with expertise in humanistic psychiatry, cultural psychiatry, and community psychiatry) will lead a discussion.

Monday, May 20, 2019

Blindspotting: An Exploration of Implicit Bias, Race-Based Trauma, and Empathy

Chair: Asha D. Martin, M.D.

Presenters: Jose P. Vito, M.D., Marcus Hughes, M.D.,

Jessica Ann Clemons, M.D., Xinlin Chen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explore topics related to systemic racism, microaggressions, implicit bias, and social class and connect these topics to social determinants of health.; 2) Understand the possible clinical presentations of race based trauma and compare it to the symptoms of PTSD.; 3) Discuss the role of the psychiatrist in addressing privilege, race related trauma, and structural racism.; 4) Explore our own implicit biases and hypothesize how these

may effect patient interactions.; and 5) Consider how empathy and other tools can be developed and used as a method to counter implicit bias.

SUMMARY:

Blindspotting is a 2018 film written by and starring Tony Award winner Daveed Diggs and Rafeal Casal. At the most superficial level, this is the story of the final three days of probation for the main character Collin (Daveed Digs) who has just been released from prison on felony charges and desperately does not want to go back. The film explores gentrification and social changes that have occurred in Oakland since Collin's return and at times Oakland is as much a character in the movie as it is a setting. Race and social class is explored through Collin's relationship with his best friend Miles who also grew up in Oakland. Although they are bonded by class, they are separated by race. As hard as Collin attempts to stay out of trouble, it seems to follow Miles who is often blinded to his privilege as a white male. In addition to gentrification and social class, race based trauma, systemic racism, implicit bias and police brutality are also explored through a poignant scene. As if life is not hard enough for Collin, on the eve of his last day of probation while rushing home to make curfew, he witnesses something that will forever change his life, a white cop shooting an unarmed black male. Collin is not able to process this event immediately but does so throughout the movie which manifests as several PTSD like symptoms (nightmares, flashbacks, avoidance and hypervigilance). At one point, Colin is literally running from the memories (black ghosts) that are haunting him. What is even more eye opening for Collin is how vastly different the media coverage of the incident is from what he witnessed. Through this event, the audience is forced to consider urban trauma and the vilification of shooting victims . At one point for example, Colin asks, "How perfect must a black boy be before we mourn him?" Following the screening of the movie, a panel of psychiatrists and psychiatric trainees will provide context for the discussion including overviews of systemic racism, microaggressions, and implicit bias. We will also explore key concepts of race related trauma. After setting the frame, we will open the floor for an interactive audience and panel discussion where we hope to further explore these

topics by examining the relationship between Colin and Myles, the gentrification and class differences present in Oakland, and Colin's life both after immediate release from prison and then after witnessing the shooting. This year as the APA will be in San Francisco, we have the unique opportunity to discuss the Bay area in the movie and further explore this conversation and its implications locally. We also hope to expand the discussion to implicit bias in clinical practice and the need for empathy and perhaps more training in cultural competencies.

Do No Harm

Chair: Maria T. Lymberis, M.D.

Presenters: Robyn Symon, C. Freeman, M.D., M.B.A., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the ways in which the culture of medicine (training and practice) is causing morbidity and mortality in today's physicians; 2) List the barriers that must be confronted both as individuals and organizationally to achieve true and lasting change in our medical system; 3) Take away caveats and pearls of wisdom from the diverse individuals in the film; 4) Be equipped to become an agent of change in today's medical world; and 5) Appreciate the value of collaboration and connection in our collective mission to keep our physicians well and safe

SUMMARY:

"Do No Harm" is a groundbreaking documentary one hour film by two-time Emmy –winning filmmaker Robyn Symon. She follows four people bonded by tragedy (the death of a medical student by suicide) on a mission to expose a toxic medical culture that begins in medical school and puts the lives of doctors and patients at risk. The film explores the complex healthcare system (bullying, sleep deprivation, assembly-line medicine) that impacts how physicians practice medicine and the environment for physicians in training. There is also a focus on solutions such as enacting legislative changes, creating novel medical practice models, eradicating the stigma attached to mental health treatment, and illuminating the narratives of physicians and their families on a healing journey.

Following the film, each discussant will speak for 5 minutes. Ms Robyn Symon will discuss how she became interested in producing the film and her three objectives: prompting a discussion of the culture of medical training; exploring the internal and external pressures in today's medical world; improving the relationship between patients and their doctors. Dr Maria Lymberis, Honorary Clinical Professor of Psychiatry at UCLA and Founding President Psychiatric Education and Research Foundation will discuss factors that prevent physicians from accessing much needed psychiatric/mental health care, especially the role of psychological defenses. Dr C Freeman, President Los Angeles County Medical Association and former Director Psychiatry Residency Training Program at Charles R Drew University of Medicine and Science will draw upon her extensive experience with trainees and practicing physicians and address their challenges, including diversity issues, as reflected in the film. Dr Michael Myers, Professor of Clinical Psychiatry at SUNY Downstate Medical Center and author of "Why Physicians Die by Suicide: Lessons Learned from Their Families and Others Who Cared" will discuss how the triad of unrelenting work and training pressures, unrecognized psychiatric illness, and vicious stigma in the house of medicine is killing doctors. Ample time will be preserved for audience interaction and discussion.

Inside OCD: I Am Not My Illness

Chair: Carol A. Mathews, M.D.

Presenters: Jaison Josekutty Nainaparampil, M.D., Michael Muhlhauser, Jeffrey Pufahl

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Distinguish between storytelling and group therapy; 2) Understand the potential effects of storytelling in the healthcare setting; 3) Identify the benefits of a storytelling program to complement care for patients with OCD; and 4) Describe best practices for storytelling programs in community settings

SUMMARY:

This media lab will begin with the performance, "Inside OCD: I Am Not My Illness," followed by a post-show discussion about the themes explored in

this performance. In 2017, The Center for Arts in Medicine at the University of Florida partnered with the UF Center for OCD, Anxiety, and Related Disorders to develop a ten-week storytelling program for individuals with OCD and their families. During the course, participants engaged in non-therapeutic storytelling regarding their experiences with OCD and collaborated with each other to transform their life stories into a collective theatrical storytelling performance. Participants then performed their show in front of a live audience and engaged in a post-show discussion focused on the diagnosis of OCD, the stigma regarding the illness and the benefits of the program. Afterwards, program participants participated in a focus group as well as a qualitative and quantitative survey. After completing the program, participants reported improved understanding of their OCD, more acceptance from family and friends, less shame and guilt related to their OCD, and more confidence about sharing their OCD story. Although the program was not designed to be therapeutic, participants did report therapeutic value. The preliminary findings of this study support the literature on the benefits of storytelling as a holistic component of care for individuals with OCD. Storytelling programs could lead to reduction in self-stigma, reduction of OCD-associated stigma within the community, and facilitation of interpersonal connections. This media lab aims to share this performance and the insight gained from this performance with all participants.

The Last Shaman: Understanding the Refractory Depression and the Possible Basis of Ayahuasca's Cultural Solutions

Chair: Maria De Falco Lucia

Presenters: Juliana Silva, Maira Rodrigues, Lara Bocato

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the cultural interpretation of depression in Native American cultures; 2) Establish current challenges in the treatment of refractory depression.; 3) Discuss the ethical issue related to the use of Ayahuasca.; 4) To trace neuropsychological possibilities of the use of Ayahuasca in psychiatric settings.; and 5) Discuss

future perspectives and ways of dealing with native American's medicine in the current psychiatric setting.

SUMMARY:

This media lab will examine the 2016 film *The Last Shaman*, that is a documentary that discusses the search for a young man, James, to cure a depression refractory to traditional psychopharmacological methods. The documentary shows moments of extreme negativism and refractoriness of the protagonist's depression, which, initially, is submitted to treatments with antidepressants of several classes and electroconvulsive therapy. Having no answer to these therapeutic options, he began to search Peru and Amazonia for methods of shamanic healing, culturally popular in these local communities of Latin America. The media covered allows the debate on the controversial use of culturally established alternatives but still without exact foundation or therapeutic proposal in scientific literature. It is also possible to discuss the cultural influence on psychopathological understanding in these tribes and the neuropsychiatric and neurobiological repercussions of the use of Ayahuasca - a psychedelic substance - in patients with a psychiatric history. Ayahuasca is composed by the N,N-dimethyltryptamine (N,N-DMT), a serotonin and sigma-1 receptors agonist, and reversible monoamine oxidase A inhibitors, such as harmine, harmaline, and tetrahydroharmine, causing changes in perception, emotion and cognition. Recent studies suggest its antidepressant potential, in addition to demonstrating its safety and tolerability. These studies associate the potential action of the substance with its role of likely long-term modulation of the serotonergic system in the HHA axis and immune system with an increase in prolactin and cortisol and reduction of CD3 + CD4, which would also affect the evolution of the depressive disorder. It is important to remember that the National Narcotics Control Board of the United Nations (INCB) does not consider ayahuasca as a controlled entity, discussed in the United Nations Convention on Psychotropic Substances, in accordance with 1971 and 1988. Our proposal is to discuss the ethical, social and mental health impact of the use of Ayahuasca in cases of major depressive

disorder including risks, biological basis, placebo effect and the dissemination of this cultural practice around the world, which is detailed in this documentary.

Tuesday, May 21, 2019

An American Tragedy: Viewing "Whitney" Critically From the Perspectives of Trauma-Informed Approach and Structural and Cultural Competence

Chair: Andres F. Sciolla, M.D.

Presenter: Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participant will be able to explain how structural stigma and trauma across the lifespan may help them engage patients who present with challenging behaviors.; 2) 2. At the conclusion of this session, the participant will be able to discuss barriers to provide effective and compassionate care with patients who engage in self-destructive behaviors; and 3) 3. At the conclusion of this session, the participant will be able to provide three or more resilience factors that may have buffered some of the childhood adversities to which Whitney was exposed.

SUMMARY:

Whitney Elizabeth Houston (1963 – 2012) was an extraordinarily talented singer of gospel and pop music who reached global stardom in the last two decades of the 20th century, before the slow, calamitous artistic and personal decline that culminated with her death by drug overdose. "Whitney", written and directed by Kevin Macdonald, is the first documentary on the artist's life to have access to Whitney's archives through Pat Houston, the singer's sister-in-law and executor of her estate. Released in July 2018 to generally favorable reviews and box office success, the movie highlighted a deep psychological divide that exists within Whitney's family. According to the movie's official website "Whitney is an intimate, unflinching portrait of Houston and her family that probes beyond familiar tabloid headlines" that uses "never-before-seen archival footage, exclusive demo recordings, rare performances, audio archives and

original interviews with the people who knew her best". The phrase "tabloid headlines" is likely a reference to their emphasis on "What's wrong?" with Whitney during her final years, when her publicly disavowed drug use was belied by erratic behavior, gaunt appearance and her splendid voice all but ruined. Instead, the documentary highlights "What happened?" to Whitney, mostly through the allegation that Whitney and her brother Gary –Pat's husband—were sexually abused during her childhood by their aunt Dee Dee Warwick. Cissy Houston and Dionne Warwick, Whitney's mother and aunt, respectively, have flatly denied the sexual abuse and its surrounding circumstances. At the same time, Whitney's ex-husband, the singer and songwriter Bobby Brown, has downplayed repeatedly the role drugs played in Whitney's deterioration and death, both publicly and in the movie. The speakers in this media session will propose the movie as a point of departure to engage the audience in a critical examination of the complex issues raised by the movie. Framing the dialogue through the perspectives of structural stigma and racism as well as historical trauma and childhood adverse experiences, the speakers will encourage the audience to answer some of the questions posed by the movie: can we make sense of the self-destructive path of this African American artist during the last part of her life? Can we do this without resorting to familiar tropes of victimhood or racial stereotypes? Importantly, as clinicians, what are the lessons we can draw from this movie to help our patients who struggle with trauma and stigma? Seeing past the treatment adherence problems, the health risk behaviors of the self-destructiveness, can we consider those behaviors as adaptations to oppression, abuse or violence, and thereby be better able to engage the strengths of individuals, families and communities, and enhance their resilience?

Foxtrot: Screening and Discussion of This 2017 Israeli Film

Chairs: Lloyd I. Sederer, M.D., Alan A. Stone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand inter-generational trauma; 2) examine the troubled soul of contemporary Israel; 3) consider the role of a

vengeful God; and 4) examine Israel's uncertain destiny through the lens of family life

SUMMARY:

Foxtrot is an Israeli film (2017) that deals with trauma in all its real and psychic variations and paradoxes. As it explores generational dynamics in one family, the film also reveals the troubled soul of the modern state of Israel. Foxtrot was criticized by Israelis in positions of authority because it touches on the smoldering political crisis that has become inescapably part of Israel's uncertain destiny. The film touches on universals of the human condition as it resonates in style with the best of 21st century art films. The story, a kind of fable, expands into an inquiry on determinism, divine providence, even suggesting that a vengeful God has taken the firstborn.

Where Have All the Black Boys Gone in Milwaukee 53206? Intergenerational Trauma Caused by Mass Incarceration

Chair: Kevin Mauclair Simon, M.D.

Presenters: Christopher James Hoffman, M.D., Glenda L. Wrenn, M.D., Marilyn Griffin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants should be able to: Describe recent trends in "mass incarceration" in the United States, and the consequences of such for the broader mental health system; 2) Discuss the impact of mass incarceration and the role of criminal justice system as a social determinant of mental health; 3) Evaluate changes in law-enforcement regulations leading to mass imprisonment and criminalization of substance use disorders and mental illness; and 4) Discuss more effective justice system structures and the psychosocial, political, and systemic challenges in reforming the U.S. judicial system

SUMMARY:

W.E.B. Du Bois remarked that the "Negro problem" involved being a Negro and an American in "one dark body." Du Bois wrote in *The Souls of Black Folk*, "He simply wishes to make it possible for a man to be both a Negro and an American, without being cursed and spit upon by his fellows, without having the doors of opportunity closed roughly in his face."

Today, these problems continue to restrain the African American community where systemic and institutional racism wreak havoc. In this media workshop, the documentary film, MILWAUKEE 53206, will serve to show the impact of a racially biased criminal justice system on the African American household, particularly black males who are incarcerated 5x higher and given sentences 10 percent longer than Whites. MILWAUKEE 53206 is a documentary that chronicles the lives of four families affected by incarceration in America's most incarcerated zip code where by the age of 34, only 38% of the men have not spent time in a state correctional facility.

Wednesday, May 22, 2019

13 Reasons Why: An Inside Look for Psychiatrists, by Psychiatrists

Chairs: Rona Hu, M.D., Christine Moutier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to consider the risks and benefits of portraying suicide and mental health issues in popular media.; 2) Participants will be able to discuss strategies for influencing depictions of mental health issues in popular media.; 3) Participants will be able to discuss with their patients and families the impact of media portrayals of mental health issues.; and 4) Participants will be able to access resources for suicide prevention and share these with their patients.

SUMMARY:

The Netflix TV series "13 Reasons Why" was one of the worldwide top ten Google searches of 2017, an entertainment phenomenon that sparked dialogue about mental health and suicide but also created controversy about whether its depiction of a suicidal teen and her struggles could inadvertently increase risk of vulnerable viewers. A bestselling young-adult novel in 2007 was optioned by actress and singer Selena Gomez, and then developed into a television series of 13 one-hour episodes. Articles in the general and healthcare media discussed whether the show should have been made at all, should have changed things from the book or not, and whether

there should have been more mental health oversight. Subsequent research found many viewers had positive effects in attitudes and behaviors¹, and another study found an association of increased Google searches for suicide related words coinciding with the release of the show². The APA Annual Meeting in New York in 2018 featured at least a dozen different presentations or symposia on the show, some by presenters who had not seen the show or read the book, but which included lively discussions and debate. This presentation will feature panelists who were involved in "13 Reasons Why". APA members Dr. Rona Hu and Dr. Christine Moutier will provide behind-the-scenes insights on how the show was created, discussions and decisions that went into the production, and the role of a psychiatrist in consulting for a show with mental health issues at its core. Excerpts from the after-show features accompanying season 1 and 2, "Beyond the Reasons" will be shown. Also joining us will be executive producer Joy Gorman Wettels, and/or showrunner and lead writer Brian Yorkey who won a Tony Award for the musical "Next to Normal", also with a mental health theme. Key points of discussion will be: Can there be responsible depictions of mental health issues and suicide in the general media? What constitutes a responsible depiction? What were the intended and unintended consequences of the show? What should psychiatrists advise schools, parents and teens?³ And what are the potential risks and benefits of psychiatrists' involvement in future depictions of mental health issues in popular media?

Psychiatry and Heads of State: *The Madness of King George*, Film (1994)

Chair: Micah J. Knobles, M.D.

Presenters: Taiwo Babatope, M.D., M.B.A., M.P.H., Zachary Joel Sullivan, D.O.

Discussants: Osman Athar, Karen Ding, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) This film screening and discussion will not review any living persons, but rather examine what role if any psychiatry has to play in times of a leadership crisis.; 2) Explore from a historical perspective how a democracy functions and responds when the head of state is impaired by

mental illness.; 3) Examine power dynamics between political leaders and psychiatrists and the suffering and vulnerability that is inherent to mental illness in kings and commoners alike.; 4) The Goldwater rule will be considered as well as the values it espouses. How ought psychiatry to respond to questions of mental illness in heads of state?; and 5) Assess how psychiatry navigates the principles of dignity for public figures and patients, respect of the profession, and security of the nation.

SUMMARY:

"I fear I am not in my perfect mind." - King Lear, Act 4, Scene 7 The Madness of King George (1994), starring Sir Nigel Hawthorne as King George III (1738-1820), Sir Ian Holm as Dr. Francis Willis, Dame Helen Mirren as Queen Charlotte, and Rupert Everett as the Prince of Wales, recounts the story of the regency crisis of 1788 when the sovereign of the Kingdom of Great Britain and Ireland began exhibiting recurrent signs of madness. Whether from the stress of losing the American colonies, acute intermittent porphyria, arsenic poisoning from fancy hats, or bipolar disorder as some historians have suggested, the King became increasingly erratic, ill-tempered, and confused. Political maneuverings ensued as the Queen and Tories (led by Prime Minister William Pitt the Younger) support the King with the hope that his illness is temporary, while the Whig opposition (led by Charles James Fox) support his inept successor, the Prince of Wales. The hapless court physicians prove unable to diagnose nor cure His Majesty's affliction with examination of the royal chamber pot, bleeding, blistering, and purging. Dr. Willis, a clergyman by training before he assumed the practice of medicine, is then consulted on his most eminent patient yet. He observes, "The state of monarchy and the state of lunacy share the frontier. Some of my lunatics fancy themselves kings. He... is the King. Where shall his fancy take refuge?" While Dr. Willis' treatments include restraints and other standards of the Georgian era employed by "mad-doctors," he also provides more enlightened methods such as exercise, gardening, fresh air, and most importantly, a dose of compassion. With the royal household in turmoil as courtiers and family members position themselves for influence and power, the King's political enemies prepare a Regency Bill. It appears the fate of the government

and the throne may rest with Dr. Willis' progress reports and ability to effect a cure. What insights might we learn from this particular crisis in leadership, how a democracy responds when the head of state is impaired by mental illness, incursions by politics and pseudoscience into psychiatry, and threats to both the dignity of patients and respectability of the medical profession alike? God save the King! God save psychiatry!

Showtime's The Affair: An Exploration of the Rashomon Effect Through Themes of Homicide, Matricide, and "Suicide"

Chair: Karen B. Rosenbaum, M.D.

Presenters: Fernando Espi Forcen, M.D., Ph.D., Susan Joy Hatters-Friedman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the meaning of the Rashomon Effect as it relates to psychiatry; 2) Understand the psychological reasons for differing eye witness accounts in homicides, using the characters in the Affair as illustration; 3) Describe common characteristics in matricide using the Affair and relevant literature; and 4) Describe common risk and protective factors for suicide using the Affair and relevant literature

SUMMARY:

The Roshomon Effect was coined after the 1950's movie by Akira Kurosawa, Roshomon, in which the characters involved each interpreted the same event in a contradictory matter. Robert Altman was quoted by the Australian Center for the Moving Image (ACMI) as saying of this phenomenon, "You see these various versions of the [story] and you are never told which is true and which isn't true which leads you to the proper conclusion that it is all true and none of it's true. So it becomes a poem." The Roshomon effect is brilliantly illustrated in Showtime's The Affair in which overlapping stories are narrated from four different characters' points of view and relevant details are different or are left out depending on who is telling the story. This effect is relevant for psychiatrists and particularly for forensic psychiatrists who are interested in teasing out what is true and what is not when performing a

psychiatric evaluation. The themes that are narrated in *The Affair* are also relevant to clinical and forensic psychiatrists and therefore this presentation will focus on the themes of Homicide, Matricide, and apparent Suicide. The first season explores a homicide from the differing points of view of the main characters. Matricide (which has been given recent media attention in the case of Gypsy Rose) is explored in season three. Season four, among other issues, deals with the psychological make-up of the character, Alison, and her disappearance which is believed to be a suicide after a long struggle with depression, self-injurious behavior and guilt over losing a young child. Although she has a history of depression, there are many protective factors against suicide including a new child and a new career. Women with a history of trauma are often at risk for intimate partner violence situations. Television clips will be shown and compared to what is known from the literature regarding these topics. This session will further allow for interaction with the audience in a Q/A format.

Presidential Sessions

Saturday, May 18, 2019

American Academy of Child and Adolescent Psychiatry Update on Childhood Psychiatric Disorders

Chair: Karen Dineen Wagner, M.D., Ph.D.

Presenters: John T. Walkup, M.D., Shashank Joshi, M.D., Matthew W. State, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the evolution of anxiety disorder across the life span; 2) List risk and protective factors in youth suicide and describe effective strategies that involve peer-adult adviser partnerships; 3) Discuss cultural issues in suicide prevention and ways to overcome barriers in implementation of culturally effective best practices; 4) Appreciate the most promising areas for precision medicine in mental disorders; and 5) Recognize the importance of screening for depression in youth

SUMMARY:

This session gives updates on the latest advances in depression, anxiety, suicide prevention, and

neurodevelopmental disorders. Dr. John T. Walkup begins with an update on anxiety disorder, by reviewing the ages of onset of the various anxiety disorders and their clinical presentations across the lifespan. There are a myriad of reasons why childhood anxiety is not identified and treated which include confusion regarding healthy anxiety and pathological anxiety, lack of awareness and advocacy as compared to other childhood conditions, and the perception that anxiety disorders are not severe or as impairing as other psychiatric disorders. As a result children with untreated anxiety are at risk to develop problems with adaptation and coping and maladaptive behaviors including substance use disorders, suicidal behavior, and nonsuicidal self-injury as they move from childhood to adolescence and young adulthood. The presentation concludes with guidance regarding identifying and treating anxiety disorder symptoms. There is a need to understand and address the factors that have led to increasing suicide rates among diverse youth. Dr. Shashank V. Joshi will highlight current trends in youth suicide and highlight best practices in culturally-attuned school-based suicide prevention. Dr. Matthew State will speak on the path forward to precision treatment in childhood neuropsychiatric disorders. The identification of genetic variants in individuals with neurodevelopmental disorders has moved from the research realm into the clinic. It is now standard of care to obtain a clinical micro-array in the assessment of any child with newly diagnosed social or intellectual disability. Soon high-throughput sequencing will make a similar transition. It is therefore increasingly important for clinicians to understand the state of the field with regard to risk genes for psychiatric conditions and how recent discoveries will likely influence diagnosis and treatment in the future. Dr. Karen Dineen Wagner, president of the American Academy of Child and Adolescent Psychiatry, will conclude by discussing her Presidential Initiative on depression awareness and screening in youth. She will also discuss the latest advances in depression treatment in children and youth.

Crosspollinating the Future

Chair: Barton Jerome Blinder, M.D.

Presenters: Ruth Myra Benca, M.D., Ph.D., Kenneth Seedman Kendler, M.D., Jurgen Unutzer, M.D., M.A., M.P.H., Randolph Martin Nesse, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review expanding areas of study and research that have important implications for advancing access to treatment, efficacy and broader understanding; 2) View how Psychiatry and related areas of study may mutually benefit from informed research and translational clinical application findings; and 3) Explore how we may facilitate dialogue and exchange of new results, insights; and innovation between Psychiatry and related disciplines

SUMMARY:

Psychiatry has benefited and contributed across scientific disciplines and areas of study in the humanities and arts. New insights, information, and tangible applications have resulted expanding our scope of knowledge in diagnosis and treatment ultimately benefiting our patients. In this Session leading workers in major areas of interdisciplinary studies will highlight salient findings and future directions for psychiatric diagnosis, treatment and insights for prevention. Panel will discuss how we might facilitate interdisciplinary study, research and translation to practice

Organized Medicine and Mental Illness: The Early History in the U.S.

Chair: John M. Oldham, M.D.

Presenters: Andrew T. Scull, Ph.D., Steven Samuel Sharfstein, M.D., Richard Kent Harding, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To review early colonial attitudes about mental illness in the US; 2) To learn about the origins of hospital-based psychiatric care in the US; 3) To become familiar with the pioneering work of Benjamin Rush; and 4) To learn about the Founding Meeting of the APA

SUMMARY:

In celebration of the 175th anniversary of the American Psychiatric Association, several invited

symposia have been planned for the Annual Meeting in May, 2019 in San Francisco, to review in broad outline the evolution of our understanding of mental illness and the remarkable transformation from colonial times (the brain as a "black box") to the present time, reflecting today's dazzling clinical and technological advances on behalf of our patients. In this first symposium of the series, presentations will focus on the primitive nature of our understanding during colonial times, followed by the advent of hospital-based care of those with severe mental illness. The contributions of Benjamin Rush will be elaborated, and the early beginnings of the American Psychiatric Association will be described.

Paradise Lost: The Neurobiology of Child Abuse and Neglect

Chair: Iqbal "Ike" Ahmed, M.D.

Presenter: Charles Barnet Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss how genetic polymorphisms and epigenetics effect psychiatric disease vulnerability; 2) Explain how a gene variation effects brain development and function so that the risk of a depressive episode or PTSD is increased; and 3) Describe how early life experience produces persistent CNS alterations and its implications

SUMMARY:

Brain imaging, neuroendocrine and neurotransmitter studies have revealed the many long-term biological consequences of child abuse and neglect. These changes underlie the increased vulnerability to mood and anxiety disorders in adulthood. Our group and others have demonstrated a number of long term neurobiological consequences of child abuse and neglect including structural and functional brain imaging changes, neuroendocrine and immune alterations. In particular, alterations in the hypothalamic-pituitary-adrenal (HPA) axis, the major mediator of the mammalian stress response, contribute to the long standing effects of early life trauma. However, not all exposed individuals demonstrate altered HPA axis physiology, suggesting that genetic variations influence the psychiatric consequences of trauma exposure. Variants in the genes encoding the CRF R1 receptor, FKBP5, PAC1,

oxytocin receptor, and others interact with adverse early environmental factors to predict risk for stress-related psychiatric disorders. Epigenetic mechanisms have now been shown to play a seminal role in mediating the effects of early life stress. These studies have suggested new molecular targets for drug development, biological risk factors, and predictors of treatment response. Patients with a history of child abuse and neglect exhibit a more severe disease course in terms of earlier age of onset and symptom severity, and exhibit a poorer treatment response to both psychopharmacological and psychotherapeutic treatments. Recognition of the biological consequences and clinical impact of trauma has critical importance for clinical service delivery, treatment research, and public health policy.

The International Medical Graduate in U.S. Psychiatry: Adversity, Advocacy, and Advancement

Chair: Norma C. Panahon, M.D.

Presenters: Antony Fernandez, M.D., Francis M. Sanchez, M.D., Fructuoso Irigoyen-Rascon, M.D., P.A., Elizabeth J. Santos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe examples of adversity that occurred during the IMGs early years; 2) Discuss the challenges and opportunities for IMGs in residency; 3) Identify how advocacy on behalf of IMGs can impact training and practice; 4) Understand how IMGs' involvement contributes and enhances the diversity of the APA; and 5) Learn how IMGs bring their unique perspectives to psychiatric care, especially in underserved communities

SUMMARY:

As the APA celebrates its 175th Anniversary, the status of the International Medical Graduate is unique and indelible. The aging of the medical workforce as well as the evolving immigration landscape only serve to highlight the need to address challenges in the provision of care. IMG's comprise as much as a quarter of physicians in the country and it is incumbent upon this group to be involved and spearhead this process. The symposium would discuss the challenges and opportunities faced by IMGs beginning with residency training and

fellowship training and integration into the workforce. The support and sponsorships of the various groups and institutions including the American Psychiatric Association, to promote and facilitate the acculturation necessary to adapt to life in the US will be discussed. The symposium will celebrate the successes and advances that have occurred with the IMG Psychiatrist through the years and identify future contributions. The panelists include Francis Sanchez MD, Antony Fernandez MD, Fructuoso Irigoyen MD and Elizabeth Santos MD

Sunday, May 19, 2019

A Recovery Tour

Chair: Edmond H. Pi, M.D.

Presenter: Curtis N. Adams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will learn recovery-oriented practices in a community setting; 2) Participants will learn about person-centered care in the community; and 3) Participants will expand their knowledge of systems-based practice

SUMMARY:

Recovery occurs in the community. It happens outside of our clinical settings. It is vital to know as much about the community as possible so that one can provide recovery-oriented, person-centered, systems-based care. Participants will experience a narrated tour of Baltimore that will inform them of the recovery-oriented services and resources that exist in an urban setting

Advancing Psychiatrists Influence Within the Criminal Justice System: Moving The Stepping Up Initiative Forward

Presenters: Judge Steven Leifman, J.D., Stephanie Le Melle, M.D., M.S., Sarah Yvonne Vinson, M.D., Michael K. Champion, M.D., Kelly Kruger, Jorge Mestayer

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List five factors that contribute to the overrepresentation of persons with SMI in the criminal justice system.; 2) Understand the extent of

the crisis, its disproportionate representation of persons of color, and the impact it is having on patients and the community.; 3) Understand how, within the Stepping Up Initiative, to expand access to treatment and supports for person with SMI in the criminal justice system.; and 4) Produce recommendations on how to increase the number of psychiatrists involved in the Stepping Up Initiative.

SUMMARY:

The number of people with mental illnesses in the U.S. jails have been at a crisis level for some time: two million individuals with a serious mental illnesses (SMI) like schizophrenia, bipolar disorder, and major depression are booked into county jails each year. We know that around three-quarters of these individuals also have a co-occurring substance use disorder. The Stepping Up Initiative is an unprecedented effort to address this issue led by the National Association of Counties, The Council of State Governments Justice Center, and the American Psychiatric Foundation. To date, over 460 counties have passed resolutions to “step up” to address the over incarceration of persons with SMI. We want to continue to move away from just talking about the issue and what we are doing and invite you to join in on the work. Psychiatrists are going to be crucial in the next stages of the Stepping Up Initiative to help identify alternatives to incarceration and connecting individuals who need support to the proper treatment. The session will include: a looking forward presentation by APA President Dr. Altha Stewart, a presentation by an individual with lived experience, a presentation by a CIT trained officer, and breakout sessions lead by Psychiatrist to address three key areas, and will end with a panel discussion moderated by Dr. Altha Stewart featuring community psychiatrist, county leaders, elected officials, Judge Steven Leifman, and individuals with lived experience. This session will be an interactive experience, where participants will be asked to engage in thoughtful conversations, come up with tangible solutions, and operationalize action steps for that will help the Stepping Up Initiative achieve its overall objective; to reduce the number of people with SMI in our criminal justice system.

Are There Structural Determinants of African-American Child Mental Health? Child Welfare—A System Psychiatrists Should Scrutinize

Chair: Danielle Hairston, M.D.

Presenter: Jacquelyne F. Jackson, Ph.D., M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe two little known ways that formal child welfare rules undermine the basis of child familial attachments and the foundation of child mental health; 2) Describe two child welfare practices leading to social class and racial bias, and disproportionate foster care induction and retention of African-American children; 3) Describe two financial incentives for the child welfare system, state and local governments to maintain and enlarge the foster care population; 4) Describe psychiatrists' role in maintaining/enlarging the foster care population and concerns about the developmental consequences of psychotropic medications for foster children; and 5) Describe two mental health implications for poor African Americans of the 2018 Family First Prevention Services Act and the Supporting Social Impact Partnerships to Pay for Results Act

SUMMARY:

The presentation will delineate four little know organizational aspects of public child welfare institutions that directly and indirectly promote compromised mental health or illness of African American children under child welfare agency supervision as well as associated developmental life paths promoting compromised mental health or illness of African American children in foster care. The demographics of adjudicated child welfare involvement—primarily foster care placement—will be addressed first. This segment will detail racial disproportionality in foster care placement, racial disparities in services to foster children that promote mental health, and specific organization rules that encourage repeated changes in foster placement that undermine child mental health. The second segment will delineate opaque practices in child welfare and dependency courts that lead to judicial findings of child abuse or neglect with questionable ethical and legal underpinnings. The practices are identified as plea-bargaining in other courts. This

segment addresses the ways in which greater economic vulnerability of African Americans promotes higher numbers of African American children being adjudicated neglected and subjected to prolonged tenure as foster children. The third segment identifies and details financial incentives for over inclusion of children in foster placement from economically vulnerable families and groups that are disparaged in American society. This segment draws on legal policy research that details the existence of a poverty industry that gives strong financial incentives to state and local governments as well as child welfare agencies to expand the number of children in foster placement without limits and prolong those placements through organization practices termed revenue maximization. This segment also gives particular attention to the role of psychiatrists in diagnosing chronic, serious mental illness in foster children, and prescribing psychotropic medicines for diagnosed foster children, along with a brief case description of this process. It will also highlight psychiatric research detailing the unknown long-term effects on children of the types of psychotropic medicines prescribed. The last segment delineates features of two associated, recently passed pieces of federal legislation designed to address the opioid addiction crisis. The presenter details structural features of those pieces of legislation that threaten to further undermine the mental health of low-income African American families and children impacted by the child welfare system in light of the ongoing structure of legislation that promotes foster placement as a poverty industry. The presenter will promote engagement with the audience by apportioning time for questions, comments or interaction with the presenter during each segment as well as at the end of the full presentation. A printed list of references for the presentation will be available.

Asian-American Mental Health Treatment and Engagement: An Update on Challenges and Opportunities

Chair: Edmond H. Pi, M.D.

Presenters: Geetha Jayaram, M.D., M.B.A., Albert C. Gaw, M.D., Hendry Ton, M.D., Chuan-Mei Lee, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the diversity of Asian American communities and learn clinical pearls in providing mental health care for Asian American patients; 2) Describe the cultural context essential for psychiatric diagnosis in South Asian American patients and how to employ culturally acceptable interventions; 3) Describe the mental health implications related to the migration and resettlement experience of Southeast Asian American patients; 4) Understand US immigration trends and future proposals and how they may affect Asian American communities and mental health; and 5) Understand cross-cultural perspectives in psychopharmacology and recognize which psychopharmacological agents are appropriate to use with Asian American patients

SUMMARY:

Asian Americans are one of the fastest growing minority groups in the United States (US). The US Census Bureau estimates that there are over 21 million Asian Americans residing in the US, representing an extremely diverse group – ethnically, culturally, and linguistically. Nonetheless, there are some common sources of stress that affect Asian American mental health, including significant stigma surrounding mental illness, pressure to live up to the “model minority” stereotype, familial obligations based on cultural traditions and values, racial discrimination, and acculturation stress or difficulty balancing a bi-cultural sense of self. More than 50% of Asian Americans are foreign-born, and a significant number do not speak English as their first language. Common barriers to care include stigma in accessing mental health treatment, language barriers, and a lack of awareness of resources and services. Our workshop seeks to highlight some of the rich and varied communities among Asian Americans, including South Asian Americans, Southeast Asian Americans, and East Asian Americans, and address pertinent challenges and future trends that affect Asian American mental health treatment and engagement. We also seek to provide an update on culturally informed interventions that may help overcome common treatment barriers.

Community Psychiatry From Past to Future: From Aftermath Psychiatry to Lattermath Psychiatry

Chair: David Alan Pollack, M.D.

Presenter: Alan Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Map the international foundations and waves or phases of development of community psychiatry, from pastoral home visits, to crisis intervention to evidence-based complex integrated packages of communi; 2) Describe the progression from deinstitutionalization to “Aftermath” psychiatry of Clinical Edifices, Fortress Hospitals, and Academic Empires with only occasional outreach, to a more hopeful “Lattermath” of new shoots of growth for a more Community-centric Rights-based psychiatry with “in-reach” to hospitals as necessary; 3) Briefly consider the final report of the Lancet Commission on the Future of Psychiatry and to offer a much bolder envisioning of the future and of the pivotal role of community psychiatry than the Report provides, for both training and consistent service delivery at both micro- and macro-levels of community psychiatry; and 4) Consider whether community psychiatry can be revitalized and sustained

SUMMARY:

The phases of development of community psychiatry, and its evidence base, both in North America and internationally, will be reviewed (1,2). The World Psychiatric Association and Lancet Commission on the Future of Psychiatry recently issued its final report (3), which will be considered, and a much bolder envisioning of the future of psychiatry and of the pivotal role of community psychiatry will be offered than the Report provides (4). The argument advanced by Terry Smith (5) about “Aftermath Architecture”, argues that architecture has been reeling since 9/11 from a widespread concern that its conceit of constructing nationalistic icons to promote “perpetual empires” has been transformed, in the public mind, into building impermanent soft targets. Smith argues that architecture has lost its way from its roots in creating homes and communities for all (5,6). Psychiatry may have lost its way in the face of the market, and since the loss of its iconic massive

institutions, is nevertheless still retreating from engaging with whole communities to improve their wellbeing and mental health, and from promoting full membership of the community while dealing with mental ill-health and disability. Instead psychiatry has continued to build clinical edifices, fortress hospitals and academic empires, with over-reliance on meds, injections, ECT, incarceration, involuntary control, alienation and neglect, which have become its dysfunctional public icons. A related concept will be invoked of the “lattermath”, a late 15th century term for new shoots of grass growing after harvest, to make the case that a renewal of psychiatry, especially community psychiatry, is imaginable (5). Our profession does not have to be left perpetually trapped in the rubble and debris of our old practices and approaches. Instead it can be demonstrated that, if examined closely, there is lattermath growth occurring in psychiatry leading to new life, new growth and new hope for the profession (5, 6). Can psychiatry revive itself with a new growth of practice innovation and evidence-based community mental health for all? Can Community Psychiatry encompass both the necessary technical interventions and service delivery systems, while also developing proxies for the culturally universal collective tasks of healing trauma, drawing on the person’s extended kinship system, peers and social movements, and enabling people to complete their rites of passage, rather than getting stuck in a timeless psychiatric limbo?

Mass Murder, Motive, and Mental Illness

Chair: James Lyle Knoll, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the psychology of mass murder; 2) Become familiar with mass murder classification; 3) Understand why gun laws focusing on mental illness are extremely unlikely to prevent mass shootings; and 4) Learn the prevention methods most likely to thwart a mass shooting

SUMMARY:

Mass shootings are extremely rare events influenced by multiple, complex factors. Yet most public debate seeks to ascribe them to only one or two primary causes. Thus far, the debate has focused heavily on

issues which are: 1) highly politicized, 2) grossly oversimplified, and 3) very unlikely to result in productive solutions. Reports of mass murderers' diagnoses are largely anecdotal, and there is little reliable research suggesting that a majority of these rare events were primarily caused by serious mental illness, as opposed to psychological turmoil flowing from other sources. A definitional problem exists, in that the lay public may be prone to ascribe a motive of "mental illness" to highly violent acts of horrific desperation. Thus, the behavior and motives of mass murderers have not been clearly distinguished from psychiatric diagnoses. This presentation will discuss what is known about the psychology of mass shooters, and why they are unlikely to be thwarted by policies designed to single out persons with serious mental illness. Rather, this represents a regressive, fearful response that provides no substantive answers to the problem of violence in society. Finally, evolving areas of forensic mental health holding greater promise for resolution will be discussed.

Psychiatry: 1944–2019—Advancing Diagnosis, Treatment, and Education—APA and the Profession

Chair: Carolyn Bauer Robinowitz, M.D.

Presenters: Herbert Pardes, M.D., Steven Samuel Sharfstein, M.D., Joel Yager, M.D., Stephen A.

McLeod-Bryant, M.D., Patrice A. Harris, M.D., M.A.

Discussants: Eindra Khin Khin, M.D., Smita Das, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine the interplay between internal and external factors shaping the directions and growth of modern psychiatry; 2) Develop understanding of the complex socio-cultural, environmental, scientific, and economic issues that have influenced the profession and patient care; 3) Assess the role and influence of education in shaping patient care and the profession itself; and 4) Gain understanding of the factors that promoted changes in attitudes about and public policy regarding psychiatric disorders

SUMMARY:

This symposium will address the evolution of the field of psychiatry over the past 75 years, beginning

with the end of World War II until the present with an emphasis on psychiatry's role and function within medicine and the mental health system, locus and content of psychiatric practice and treatment, education, and work force, as well as the influence of the American Psychiatric Association. Following a brief linear overview of major dates and events in and about the specialty, there will be a series of in-depth presentations assessing the importance of scientific advances in diagnosis and treatment and psychiatry's relation to other medical specialties, as well as the role of external environmental, socio-cultural, and economic factors on the shape of the profession. These analyses will address challenges and controversies as well as successes and will additionally consider the involvement of groups such as advocacy organizations, federal and state government, and the justice system. The presenters themselves worked in and lived through many of the events of the last fifty years. Thus, in addition to their theoretical understanding of the multiple factors shaping the process of change, they will include more practical examples from their real world, on-the-ground experiences, using lessons learned as a basis for future planning.

The 175-Year History of African Americans in Psychiatry

Chairs: Rahn K. Bailey, M.D., Donna Marie Norris, M.D.

Presenters: Billy Emanuel Jones, M.D., Steven M. Starks, M.D.

Discussant: Ezra E. H. Griffith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify challenges in American society that may have influenced the mental health of the African American community.; 2) Discuss the possible solutions to mental health concerns in the African American community.; and 3) Highlight the APA role in implementing practical remedies such as increasing research to impart meaningful change.

SUMMARY:

Over the past decade, commentary in American culture, sparked by the election of Barack Obama to the U.S. Presidency, has considered the possibility of a post-racial American society. Intellectuals of all

persuasions have suggested that the old black-white dichotomy is now old news. However, is this pervasive sense of progress, and contentment widespread among African Americans (AA)? Racism and racial segregation have left their mark on the mental health (MH) care of AA patients in the United States, even as the civil rights movement of the 1960/70s produced its own effects on the rights of AA patients and on the futures of AA all health care professionals. The increased attention to the healthcare disparities in outcomes of mental health care between AA/all groups, the significantly improved climate in which health care research is carried out with AA populations, and the enhanced access of AA professionals to a broad spectrum of training throughout the country, including the APA, has all lead o a crescendo including the election the first AA President of the APA, who began in May 2018. It is time to reflect on AA individuals' needs in mental health care, as well as the efforts of AA psychiatrists and MH professionals whose training and clinical, research, and teaching activities are relevant to providing care for AA. This session takes a comprehensive and candid look at the psychiatric well-being for AA relating to patient care, training, and research in the current cultural context. The presenters will provide personal narratives of the past and their expectations of what the future may hold for the care of the AA community. The session will explore the different aspects of patient care—the unique challenges of delivering psychiatric care to a historically disenfranchised AA population—and offer creative ways of addressing these challenges.

Monday, May 20, 2019

Advances in Psychodynamic Psychiatry

Chair: Jennifer I. Downey, M.D.

Presenters: Richard C. Friedman, M.D., Cesar A. Alfonso, M.D., Joanna E. Chambers, M.D., Andrew J. Gerber, M.D., Ph.D.

Discussant: Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Realize that psychodynamic psychiatry is an emerging new area of knowledge.; 2) Learn that a psychodynamic assessment or formulation helps direct treatment in every

psychiatric patient even if he or she may never be a candidate for individual psychodynamic psychotherapy.; 3) Learn that childhood experiences may influence symptoms and syndrome formation as well as the capacity to cope with adversity. The representations and memories of childhood events may be unconscious.; 4) Realize how modern applications of psychodynamic psychiatry, using the developmental biopsychosocial model, contribute to collaborative care and treatment for patients in the most diverse cultures.; and 5) Understand how modern psychodynamic concepts enlighten the diverse kinds of clinical, educational, and research work the different psychotherapy presenters do.

SUMMARY:

Psychodynamic psychiatry, an emerging new field, derives from four sources—psychoanalytic thought but also, and equally, from academic psychiatry , academic psychology, and from neuroscience. Modern psychodynamic psychiatry does not concern itself with controversies between schools of psychoanalysis that have never been resolved. Rather, it focuses on insights that originated in the psychoanalytic movement but have now mostly been subject to empirical validation. An example is the importance of childhood development to understand psychopathology in adults as well as to understand positive traits developed in childhood such as the capacity to cope with adversity. Childhood experiences have been demonstrated to influence symptoms and syndromes in over half of adult psychiatrically ill patients. Trauma in childhood is associated with severe psychiatric manifestations in adulthood including borderline personality disorder, dissociative disorders, and post-traumatic stress conditions. In addition to considering the importance of childhood development to understand any psychiatric patient, psychodynamic psychiatry also encompasses the importance of the unconscious since many representations and memories of childhood events will not be consciously remembered yet powerfully motivate the individual's behavior. Childhood experiences may also affect an individual's relationships with others including with the clinician. In the clinical situation, these effects are called transference. Presenters in this symposium will demonstrate how taking a childhood developmental history benefits

the understanding of every patient. Thus a psychodynamic assessment will inform and enhance treatment planning even if the patient would never be a candidate for individual psychodynamic psychotherapy. Whatever treatment or treatments the patient may require—whether medication, manual-based individual psychotherapies such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), group and family therapies, and other specialized interventions both somatic and psycho-social—will be more effective if the clinician understands the developmental experiences that have impacted the patient’s psychology, affects, and behavior. An interest in a patient’s development also enables the clinician to understand better diverse patients from other ethnic, cultural, and religious backgrounds. The developmental biopsychosocial model, first proposed by George Engel in the early 1950’s, is highly beneficial for understanding any new patient and choosing from among the much more numerous therapies that psychiatrists have at their disposal today. It enables us to work collaboratively with other medical professionals. Further, when a therapy does not help a patient, psychodynamic psychiatry offers tools to understand why it hasn’t done so and what intervention might be most beneficial to employ next.

American Psychiatric Association and Japanese Society of Psychiatry and Neurology: History and Future Visions for Collaboration

Chair: Tsuyoshi Akiyama, M.D., Ph.D.

Presenters: Altha J. Stewart, M.D., Mitsumoto Sato, M.D., Ayana Jordan, M.D., Ph.D., Michael Christopher Hann, M.D., Ai Aoki

Discussant: Bruce Jan Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the history of collaboration between APA and JSPN; 2) Understand the future visions for collaboration between APA and JSPN; and 3) Understand the significance of collaboration between APA and JSPN

SUMMARY:

The American Psychiatric Association (APA) and the Japanese Society of Psychiatry and Neurology (JSPN)

are committed to lead psychiatry and psychiatric care in the pacific region. With due differences in the national medical care systems, the two organizations share the aspiration for science, improvement of care and collaboration with other stakeholders around psychiatry and mental health. The collaboration between APA and JSPN has had many achievements and much more should be attained in the future. In this symposium, the representatives will present the history and future visions about the collaboration between American and Japanese psychiatry. Prof Mitsumoto Sato will present the history and the episodes of collaboration between Japanese psychiatrists and American psychiatrists, focusing on academic conferences. Early career psychiatrists will present how they are carrying out international activities with the aim to develop collaboration between the two organizations.

APA in Action: How Advocacy Can Positively Impact Your Practice and Your Patients

Chair: Patrick S. Runnels, M.D.

Presenters: Steven M. Starks, M.D., Mary Helen Davis, M.D., Cassandra F. Newkirk, M.D., Harsh K. Trivedi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To provide members with a better understanding of the breadth of advocacy efforts undertaken by the APA, the importance of advocacy, and ways to increase their involvement; 2) will learn about successful advocacy efforts from APA member experts who will speak from their personal experience with legislative, administrative, and other forms of advocacy at the federal and state; and 3) discuss legislative advocacy using primary example of efforts to retain funding for the Minority Fellowship Program after the Trump administration proposed eliminating it

SUMMARY:

The workshop will provide members with a better understanding of the breadth of advocacy efforts undertaken by the APA, the importance of advocacy, and ways to increase their involvement. Attendees will learn about successful advocacy efforts from APA member experts who will speak from their personal experience with legislative, administrative,

and other forms of advocacy at the federal and state level. The panel will discuss: APA's legislative advocacy efforts to retain funding for the Minority Fellowship Program; regulatory efforts around new codes and payment models to ensure access to high-quality and efficient care; and APA's engagement with district branches at the state level on legislation and building strong coalition partners.

Black Psychiatrists and Their Community Commitment

Chair: Ezra E. H. Griffith, M.D.

Presenters: Billy Emanuel Jones, M.D., Morgan M. Medlock, M.D., M.P.H., Napoleon B. Higgins, M.D., Carl Compton Bell, M.D., Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss methods of commitment to the community; 2) Discuss the role of publications as action; and 3) Place commitment in historical perspective

SUMMARY:

Recent discussion among black psychiatrists has focused on the use of the written word to concretize ideas about improving black communities and making them truly therapeutic spaces. This workshop highlights four brief presentations, followed by audience discussion. Speakers will articulate unique approaches to influencing their black communities. The common element is their use of published texts to circulate their ideas, to evoke commentary and reflection, and thereby to produce community change. Dr. Jones will discuss his role in editing a book that brought together psychiatrists, psychologists, and public health specialists to discuss their work. The result was historical narratives, ideas about caring for black patients, teaching trainees in the mental health professions, and carrying out scholarly inquiry. Dr. Medlock also edited a recent text. But she additionally authored a chapter on the role of the black church in contributing to the therapeutic nature of black communities. She will start from the notion that the black church has had a long history in combating racial discrimination. Her scholarly theological background reinforces her call for the black church to join the psychiatric profession in

contributing to change in the black community. Dr. Higgins will take a position related to praxis, as he and his colleagues have focused their text squarely on individuals and families affected by mental illness. Within the black community, those persons contend with disabilities that compound the mundane struggles against the effects of racism. Thus, his contributions target those more directly and acutely in need. Dr. Bell has produced a science-based text that explores ways of combating the deleterious effects of alcoholism, especially in pregnant black women. From that point he will argue that for the black community, bio-medical scholarship should be linked closely to relevant extant community problems. Researchers should also understand that their conclusions must be used to influence the development of public policy that concerns community health. Dr. Stewart will provide commentary on the four presentations. This workshop emphasizes renewed and concerted emphasis on the connection of place and health.

Dream-A-World Cultural Therapy and Cultural Resiliency: Multimodal Primary Prevention Mental Health Interventions in High-Risk Primary School Children

Chair: Nancy Diazgranados, M.D.

Presenter: Frederick W. Hickling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Comprehend how the Dream-A-World-Cultural Therapy (DAW-CT) program and Dream-A-World-Cultural Resiliency (DAW-CR) emerged from psychohistoriography and Psychohistoriographic Cultural Therapy (PCT); 2) Understand the development of a primary prevention mental health program transitioning from a proof-of-concept to a scale-up model, and finally to a national transition-to-scale program; 3) Comprehend the difference between Dream-A-World-Cultural Therapy (DAW-CT) and Dream-A-World-Cultural Resiliency (DAW-CR) and their different applications.; 4) Understand how Dream-A-World-Cultural Therapy (DAW-CT) program and Dream-A-World-Cultural Resiliency (DAW-CR) can be applied to Grade 4 primary age school children.; and 5) Comprehend the outcome effects and differences of the Dream-A-World-Cultural Therapy (DAW-CT)

and Dream-A-World-Cultural Resiliency (DAW-CR) programs applied in Jamaican children.

SUMMARY:

Psychohistoriography is a psychological analytic method pioneered at the Jamaican Mental Hospital in 1978 evolving into a unique treatment model of Psychohistoriographic Cultural Therapy (PCT), synthesizing large group psychotherapy process and psychohistoriographic dialectic analysis integrated in patient performances engaging creative and dramatic arts. The novel primary prevention mental health institute (CARIMENSA) developed Dream-A-World-Cultural Therapy (DAW-CT) embedded with principles of PCT into a school based multimodal primary prevention resilience promotion intervention promoting prosocial behaviour change in high risk children and involving teachers. This 240 hour program over 2.5-years pioneered an action research control-trial proof of concept project with 30 inner-city Kingston primary school children and 30 controls, was replicated in July 2013 as a scale up control-trial with 100 children and 100 randomized controls, in four inner-city Kingston primary schools in disadvantaged communities with high rates of violence and trauma. Redesigned as a nine-month in-school transition-to scale Dream-A-World Cultural Resiliency (DAW-CR) pilot project for 1750 children from 70 schools between 2014-2016 in Eastern Jamaica, in 2017-18 was implemented as a new-randomized proof of concept program with 329 children and 330 randomized controls in 20 schools in Eastern Jamaica. The Achenbach System of Empirically Based Assessment (ASEBA) served to measure externalizing and internalizing symptoms to monitor adaptive and dysfunctional behaviours. Both the DAW-CT and the DAW-CR cohorts showed a significant reduction ($p < 0.05$) in the number of children having borderline and clinical conditions (social problems, attention problems, rule-breaking, externalizing problems and total problems on the syndrome scale) compared with the controls. Of the cohort of children in the final DAW-CR study, 91% had experienced a mean of 2.90 ± 1.904 adverse childhood experiences (ACE's), with physical abuse being most prevalent, followed by emotional abuse, neglect and abandonment. Sexual abuse had the lowest prevalence. Most of these children presented disruptive behaviours including hyperactivity,

Oppositional Defiant Disorder, Conduct Disorder as well as internalizing symptoms and Somatic Problems. The children with high ACE's (physical abuse and neglect) exposed to DAW-CR showed significant reduction in clinical problems, learning, behaving appropriately and increased academic motivation compared with the controls ($p < 0.05$) after 9 months. The cost per child for the DAW-CT module was US\$2,500 compared with US\$130 per child for the DAW-CR module. The DAW-CT & CR programs are robust primary prevention program for the reduction of behavioural dysfunction and academic underperformance in Grade 4 Primary School children in Jamaica. DAW offers a multimodal school based prevention interventions that can transition to LMIC and disadvantaged communities.

Mental Health Status of African Americans: Challenges and Opportunities

Chair: Glenda L. Wrenn, M.D.

Presenter: Patricia Newton, M.D., M.A., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the historical, geopolitical, and sociocultural factors affecting the mental health of African people in the United States of America and the Diapora; 2) Clarify the barriers that African Americans face in receiving comprehensive and culturally competent mental health care; 3) Identify the educational, research and training factors needed to improve mental health treatment and improved patient outcomes in African American populations; and 4) Encourage advocacy in mental health professionals and associations relative to cultural competency and funding priorities for African Americans and other underserved populations in the United States o

SUMMARY:

African Americans have been identified as constituting approximately 13 – 14% of the total population in the USA. Approximately 16% of this population group have been identified as having a mental disorder. Data supports that only about 50% of this identified group ever receive any mental health care and for those African people of Caribbean only 25% of this population receive

mental health treatment. Thus, this population represents a major undiagnosed and underserved group for which multiple barriers to care exist and impede adequate treatment regardless to age, gender and economic status. The impact of inadequate diagnosis and treatment of mental disorders in this population severely affects the quality of life in this population and creates a burden in terms of overall health care costs due to co-morbid conditions and increased health care costs. This lecture will explore factors impacting the accurate diagnoses and comprehensive treatment in African Americans and the impact that this service gap has on the mental health of this population group as well as its intersectionality with that of general health and well-being. Issues related to accessibility to care, adequate and comprehensive care, workforce development relative to cultural competency will be explored. A look at defining research priorities relative to the inclusion of African Americans in clinical trials so that meaningful data collection and treatment protocols can be developed will be discussed as well, The impact that this lack of knowledge has for the improvement of patient outcomes will be reviewed. Finally, opportunities for improving dialogue as well as patient outcomes and decreasing morbidity and disability due to mental illness in this patient population will be highlighted to provide the incentive for future research and discussion. This will be coupled with the direct relationship to cost factors that are driving factors in the delivery of more comprehensive and cost effective services to African Americans and other underserved groups relative to health care in general.

Modern Techniques for Unraveling Depressions, Suicide, and the Underline Physiology of Their Diagnosis and Treatment

Chair: Herbert Pardes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apprise psychiatrists generally of new and exciting research that has an impact on clinical care; 2) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 3) Integrate knowledge of current psychiatry into discussions with patients; 4) Identify

barriers to care, including health service delivery issues; and 5) Apply quality improvement strategies to improve clinical care

SUMMARY:

This Presidential Symposium will feature four rising stars in psychiatric research. It is exciting to consider the enlightening statement from one of our presenters “the various challenges in diagnosing and treating depression” have been attributed in part to the fact that our diagnostic system of science assigns a single label to a syndrome that is not unitary and that might be caused by distinct pathological processes, which thus would require different treatments.” The symposium will illustrate how modern science is enabling us to rethink how to both assess and diagnose depression and also how to treat it. This should lead to more specific and accurate diagnosis, and more and better treatment choices. Of related interest is the fact that scientists are working to assess the way better information and techniques regarding biology often starting from the biological characteristics which relate to illnesses may be a more productive way of subsequently understanding diverse kinds of depression or other psychiatric illnesses rather than an approach which starts with clinical symptoms. This work is related to figuring out how to best avail ourselves of newer treatment possibilities such as; e.g. ketamine and transcranial magnetic stimulation. Some of the latest techniques for understanding circuit dysfunction are using two full time imaging and optogenetic tools to visualize and experimentally manipulate the survival of newly formed synapses. This is integral to figuring out how prefrontal cortical synapse genesis is required in maintaining the antidepressant behavioral effects of ketamine in the week after treatment. In the presentation, one approach suggests patients with depression can be subdivided into four neurophysiological subtypes defined by distinct patterns and dysfunctional cognitive and limbic frontal striatal networks. These biotypes which cannot be differentiated solely as a result of clinical features are associated with different clinical-symptom profiles. They also predict responsiveness to transcranial magnetic stimulation therapy. These efforts may become useful for identifying individuals likely to benefit from targeted neurostimulation therapies. Also presented will be information on

wearable devices as a tool that can help in mental health monitoring. Further, there will be discussion of a multi modal approach for assessing when depressive symptoms unfold and how injurious and suicidal behaviors develop. These various approaches should be helpful in illuminating how modern technological approaches can contribute to clinical care of patients with psychiatric illnesses.

Silence Is Not Always Golden: Interrupting Offensive Remarks and Microaggressions

Chair: Kat Morgan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to identify their options when they hear something offensive; 2) At the conclusion of this session, the participant will be able to formulate what to say when someone says something offensive; and 3) At the conclusion of this session, the participant will be able to take advantage of those moments when they hear something offensive to effect positive change

SUMMARY:

Speaking up is a skill. This practical and interactive workshop will help you figure out what to say when you hear - or overhear - something offensive. Whether you just overheard coded language in a meeting or your uncle just used a slur at a family dinner or a colleague upset another colleague and doesn't even realize they did so, how do you respond? If you've ever overheard something that made you uncomfortable and you wanted to respond but didn't, this workshop is for you. If you've wanted to say something but felt uncertain of what words to choose, this workshop is for you. If you haven't spoken up and regretted it later, this workshop is for you. If you have spoken up but feel like you blew your chance, this workshop is for you. Come learn to speak even when your cheeks flush and your adrenalin surges. This workshop will involve hands-on practice, techniques, and tools. Through a combination of reflection, role plays, didactics, and video, you'll identify your options for action when you hear something offensive. You'll be able to formulate what to say or do when someone says something offensive so you can take advantage

of those moments and effect positive change. We'll watch Silence is Not Always Golden, Kat Morgan's TEDxCharleston Talk. We'll cover recognizing triggers because, unmanaged, they can impede effective responses to offensive comments. We will cover the effects of micro aggressions on both bystanders and targets. We will work with two response models for those who witness harassing or offensive behavior. We will explore the 5Ds (options for bystanders who witness harassment): Direct, Distract, Delegate, Delay, Document. We'll cover the LARA process: Listen, Affirm, Respond, Add. We'll plan and practice responses that interrupt offensive dynamics and also have the potential for establishing respectful ones.

Spirituality and Mental Health: A New Frontier for Promoting Emotional Wellness?

Chair: David H. Rosmarin, Ph.D.

Presenters: Paul Summergrad, M.D., Sidney H. Hankerson, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe positive and negative effects of spiritual/religious practice on mental health.; 2) Describe the boundaries between mental disorders and other forms of human suffering, and understand how spiritual teachings can provide an alternative approach to mental health.; and 3) Understand how collaborations between mental health professionals and faith communities can enhance access to care and promote emotional wellness.

SUMMARY:

Despite remarkable advances in basic neuroscience and clinical innovations in pharmacology, neurotherapeutics, and psychotherapy over the past two decades, the burden of mental disorders continues to grow at an alarming rate. According to the National Institute of Mental Health, more than 20% of Americans experience a mental disorder in every given year, and lifetime prevalence for some disorders encroaches upon 50% of the population. Worse, suicide is the leading cause of death among young adults and teens, and is more than twice as common as homicide. For a variety of reasons, the combined mental health disciplines were reluctant to turn to spiritual traditions for solutions

throughout the 20th century. This longstanding trend has begun to change with the advent and widespread promulgation of mindfulness-based treatments (which have clear Buddhist origins), efforts on the part of the Substance Abuse & Mental Health Services Administration (SAMHSA) to collaborate with faith-communities in delivering mental health care, and numerous developments around the globe in the science of spirituality and mental health. Indeed, the vast majority of Americans profess strong spiritual beliefs and identity, and several recent studies suggest that the statistical majority of psychiatric patients wish to discuss spiritual matters in the context of their treatment. This presidential session will broadly address the question of whether spirituality may provide a new frontier for promoting emotional wellness. Panelists will: (1) Summarize recent research findings and provide an evidence-based conceptual framework for addressing spiritual issues in treatment; (2) Describe how spiritual teachings regarding suffering and “letting go” can provide an alternative approach to mental health; (3) Discuss how collaboration with faith-communities can reduce stigma and increase access to quality mental health care.

The Dawn of the Modern Era: Reforms in Care and Treatment (1844–1944)

Chair: Jeffrey Lee Geller, M.D., M.P.H.

Presenters: Margarita Abi Zeid Daou, Jacqueline M. Feldman, M.D., Roger Peele, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how decisions made by psychiatrists and politicians made between 1844 and 1944 continue to affect us, some would say hound us, to this day; 2) Understand how far we had come in institutional-community relation between 1844 and 1944, before we abandoned this course only to have to started it anew decades later; 3) Understand how the developments in forensic psychiatry 1844-1944 lay the foundations for contemporary American jurisprudence’s effects on persons with mental illnesses; and 4) Understand how advances in psychiatric treatment by women and for women 1844-1944 changed the practice of all fields of medicine

SUMMARY:

In October, 1844, 13 psychiatrists (8 from public and 5 from private institutions) came together to form The Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) “to communicate their experiences to each other, cooperate in collecting statistical information relating to insanity, and assist each other in improving the treatment of the insane.” The American Journal of Insanity (now the American Journal of Psychiatry) started by one of these psychiatrists a few months before this meeting became the official vehicle of communication for the Association. This symposium focuses on how we’ve done in meeting the Association’s objectives over the first 100 years of work by the American Psychiatric Association and the intended and unintended consequences of these efforts. The symposium will focus on how political decisions, socioeconomic variables, and scientific advances made during this 100 year period continue to affect psychiatrists, individuals with mental illness, and the practice of psychiatry in fundamental and profound ways. We will focus on funding, women psychiatrists and female patients, forensic psychiatry, and the relationships between intuitional and community services.

The RCPsych Gatsby/Wellcome Neuroscience Project: How to Interest and Engage Clinicians in Neuroscience

Presenter: Wendy Katherine Burn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what is being done in the UK to introduce more knowledge of neuroscience into the Psychiatry training curriculum and to clinicians; 2) Understand the relevance of neuroscience to everyday clinical practice; and 3) Will be aware of some of the latest work in neuroscience and neurogenetics

SUMMARY:

In the UK in 2016 the Royal College of Psychiatrists was given a generous grant from the Gatsby Foundation and Wellcome Trust for a 2-year project to introduce changes to the Psychiatry training

curriculum. The aim was to make sure that training focused more on the exciting advances in basic and clinical neuroscience, so that trainees were better equipped to provide excellent mental health care in the future. We wanted trainees to be able to develop and deliver innovative biomedical approaches to the diagnosis and treatment of adult mental health, neurodevelopmental, and neurodegenerative disorders. This session will describe how the project successfully transformed training in the UK. Clinicians became engaged and there was a general rise in interest in neuroscience in the Psychiatric workforce. Alongside a new curriculum for neuroscience, training programs and resources were developed to ensure excellent teaching and a high-quality learning experience. The College has been awarded a further 3 years of funding to embed these developments. Some of the recent advances in neuroscience and neurogenetics will be described to illustrate how they will eventually change the practice of Psychiatry and why it is essential that modern neuroscience is integrated into psychiatric education.

Transition of Psychiatric Practice to the Total Health (Medical/Pediatric) Setting

Chair: James Ray Rundell, M.D.

Presenters: Roger Gerald Kathol, M.D., Jeffrey T. Rado, M.D., Gary R. Maslow, M.D., M.P.H., Peter Aran, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the challenges and costs faced by adult/child medical patients with behavioral health (BH) conditions in getting psychiatric care, knowing most do not to go for treatment in the BH setting; 2) Describe inpatient, outpatient, rehabilitation and ER integrated psychiatric programs in the adult/child medical settings with evidence-based health-improving components and a system-based ROI; 3) Describe the role that psychiatrists must play in formulating and delivering adult/child behavioral health services in value-based inpatient, ER, and post-acute care medical settings; and 4) Strategize priorities for development and payment for integrated medical and psychiatric services in medical settings while retaining needed BH setting services

SUMMARY:

In today's world, most psychiatrists are compelled by existing payment models to practice independently from all other medical practitioners in standalone behavioral health (BH—includes both mental health and substance use disorders) settings, often using non-communicating documentation systems. This creates a challenge for the 16% of patients with BH conditions, only 30% of whom access services in the BH sector. Of the 70% of BH patients accessing health services only in the medical sector, often with comorbid medical and BH conditions, fewer than 15% receive outcome-changing BH services, which leads to elevated health care costs, in the US \$406B annually. Actuarial data suggest that moving psychiatrists and psychologists to the medical setting would facilitate consistent treatment of these patients, and could be paid for by less than 10% of the \$406B cost overage in medical patients with BH conditions. This problem is created by the separate medical and BH payment systems, which makes it exceedingly difficult for psychiatrists to coordinate their care with other adult and pediatric medical providers, preventing effective BH treatment in the medical setting and medical care in the BH setting. This Academy of Consultation-Liaison Psychiatry (ACLP)-sponsored symposium will categorize the shortcomings of stand-alone psychiatric practices from the viewpoint of a primary care internist and former Blue Cross administrator (what BH services medical practitioners need but do not have) and a "total health" management consultant who has spent 25 years helping care delivery systems, medical health plans, government agencies, and employers try to integrate services in a system that does not pay for integrated care. These presentations will be followed by a review of inpatient, outpatient, and emergency room models of value-based integrated adult and pediatric services from the perspectives of a jointly boarded internist/psychiatrist and triple boarded psychiatrist/pediatrician/child psychiatrist. Many of the adult services have evidence of return on investment or substantial cost savings. Though fewer comparative studies have been performed in the pediatric patients, some have evidence of efficacy while others would logically follow with improved health outcomes for children and adolescents. The

final presentation will systematically discuss the changing role of psychiatrists and psychiatry in the delivery of health care. In previous decades, consultation-liaison psychiatrists' primary role was to serve the needs of general hospital medical-surgical inpatients. Today, however, C-L psychiatrists, and in a sense, all psychiatrists, will take on consultation-liaison roles in outpatient, inpatient, rehabilitation, and emergency medical settings. Further, much of what is now stand-alone, psychiatric care will become a core part of total health care since we now know that the interaction of the two is so robust.

Treating Opioid Use Disorder: What Every Psychiatrist Should Know

Chair: Shelly F. Greenfield, M.D., M.P.H.

Presenters: Kevin Allen Sevarino, M.D., John A. Renner, M.D., Larissa J. Mooney, M.D., Richard Ries, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify recent trends in opioid misuse and the epidemiology of opioid use disorders in the U.S.; 2) Identify three evidence-based non-opioid treatment modalities for chronic pain.; 3) Describe the three FDA approved medications for the treatment of OUD and important pharmacologic characteristics of each medication; 4) Apply knowledge of opioid, alcohol and drug effects as leading to or complicating suicidal conditions; and 5) Specify key gender/sex differences in opioid use disorders and apply this knowledge to implications for treatment including treatment of pregnant women with OUD

SUMMARY:

Overview: The rise in opioid use disorders (OUD) and opioid overdose deaths has brought public attention to the need for increased access to evidence-based treatment for OUD and other substance use disorders in the U.S. This symposium will first present the epidemiology and scope of the opioid problem in the U.S. and then present the evidence-based medication therapies for Opioid Use Disorders (OUD), as well as the behavioral adjunctive treatments including treatment of co-occurring conditions. The symposium will present sex and

gender differences in epidemiology and implications for treatment including treatment of pregnant women with OUD. Finally, the symposium will discuss suicidal behavior in OUD and its treatment and prevention. More specifically: (1) Dr. Kevin Sevarino will provide the overview, scope of the OUD problem, and its epidemiology (30 min). (2) Dr. Renner will then review medication treatment for OUD presenting the clinical considerations in prescribing each of the three FDA approved pharmacotherapies for OUD: methadone, buprenorphine/naloxone, and naltrexone-XR. Methadone is a full agonist at the mu opioid receptor that is dispensed in federally regulated Opioid Treatment Programs. Buprenorphine/naloxone (BUP/NX) can be used in a wide range of clinical settings often best provided when integrated into primary or psychiatric care clinics or subspecialty practices that can accommodate the unique clinical needs of the individual patient. Extended-release naltrexone(XR-NTX) is an antagonist at the mu receptor and is administered as a monthly injection. All three medications for treating OUD have been well studied and demonstrated to be highly effective and life-saving in comparison to medical withdrawal treatment and the range of "drug-free" treatments for OUD (30 min). (3) Dr. Mooney will present approaches to further optimizing OUD treatment outcomes with medication treatment using ancillary behavioral therapies, as well as the treatment of comorbid conditions that must be addressed in order to improve overall health and sustain the gains of OUD treatment. Her presentation will discuss the prevalence rates and assessment of disorders that commonly co-occur with OUD, such as other substance use disorders, psychiatric disorders, and chronic pain conditions (30 min). (4) Dr. Greenfield will present key gender and sex differences in the current prevalence of and risk factors for opioid use disorders and apply this knowledge to implications for OUD treatment including treatment of pregnant women with OUD (30 min). (5) Dr. Ries will review statistics on the role of opioids, alcohol and other drugs as causes or complications of suicidal conditions, as well as the gray areas between accidental overdose death and purposeful suicide. He will outline safety plans for both addiction related suicide and overdoses (30 min). (6) We will

conclude with a panel discussion and audience question and answer session (30 min).

Why Are We Still Waiting: Resistance to Prevention and Promotion With Mental Health Issues

Chair: Altha J. Stewart, M.D.

Presenter: James P. Comer, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To think about public health issues in mental health; 2) Have a historical lens on child development in education; and 3) Consider sources of resistance to innovative practice

SUMMARY:

This presentation describes an education intervention project that emerged out of the racial unrest and efforts to promote social justice in the late 1960s. In response to a Ford Foundation challenge grant the Yale Child Study Center invited the principle investigator, James Comer, to find a way to help make it possible for African American children to achieve at the same academic levels as other groups. The same push for social justice led to the creation of a Black Caucus within the American Psychiatric Association; and eventually, the Black Psychiatric Association. At a critical time in the infancy of the Yale work the Minority Center of the National Institute of Mental Health, created through the advocacy of the BPA and APA, provided funds needed to enable the Yale intervention project to survive and, in time, inform national school and education policy and practice. It describes how the intervention project, now called the Yale University School Development Program, decided not to focus on school integration, not to impose an established intervention method on pilot schools, or to attempt to overcome apparent participant deficits—students, parents, teachers, or policies. The innovative method chosen, was to live in and learn about schools and to help school stakeholders develop an internal or organic change process model that promoted effective adult stakeholder interactions and functioning that in turn greatly improved school environments or cultures; facilitating student engagement, development and learning. The structures, guidelines and operations that were created to manage the change process

became the non-negotiable project framework. The concept and operations are based on public health, ecological and psycho-social principles and practice. The presentation describes how the model was successfully field tested and disseminated primarily in low-income, African-American schools, but also in schools across socio-economic and ethnic spectra, and provides past and recent evidence of its success. It discusses intended and unintended conceptual, political and economic obstacles to the change process. Finally, it discusses how this work provided a pioneering model and touchstone for the current national whole child focus and movement in education, particularly as presented in the 2019 Aspen Report, From a Nation at Risk to a Nation at Hope. Finally, the presentation strongly suggests that new and practicing educators can be the central carriers of a child-development based mindset and way of working that is in line with what modern sciences now knows about why and how children learn and behave. And that educational-political-economic leadership collaboratives must provide preparation, promotions and protection for a community whole child-based approach to education at local, state and national levels.

Women and Psychiatry: Past, Present, and Future

Chair: Elissa P. Benedek, M.D.

Presenters: Carolyn Bauer Robinowitz, M.D., Cheryl D. Wills, M.D., Olaya Lizette Solis, M.D., Carol C. Nadelson, M.D., Tanuja Gandhi, M.D., Renée L. Binder, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review of historical contribution of women to psychiatry; 2) Review of historical contribution of women to APA; 3) Review of historical contribution of women to allied organizations; 4) Future of women in psychiatry; and 5) Future of women in allied organizations

SUMMARY:

The role of women in the APA began with the committee on women. Women then assumed leadership positions on other committees and the Board of trustees. Finally there was the first woman president. Other women followed and each had a unique agenda for the organization . As the APA lead

other professional organizations followed. Each member of the workshop will discuss her critical role or roles in the organization, and what changed during her tenure. Each presenter will also comment about her view of the future of women in APA and allied organizations.

Tuesday, May 21, 2019

A Conversation on Diversity With APA Members

Chair: Ranna I. Parekh, M.D.

Presenters: Vabren L. Watts, Ph.D., Eric Yarbrough, M.D., Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Give APA members an opportunity to share experiences, history, and perspectives about diversity in organized psychiatry; 2) Develop strategies to increase diversity and inclusion among all APA members; 3) Discuss how health care and patient demographics are impacted by diversity; and 4) Share ideas that will help APA better serve its minority and underrepresented (M/UR) constituents, and patients a part of underserved communities

SUMMARY:

Since 2015, APA's Division of Diversity and Health Equity (DDHE) has sponsored Conversations on Diversity at APA Annual Meetings and the IPS: The Mental Health Services Conference. These sessions provide a setting in which attendees of all backgrounds can share their experiences and perspectives about diversity, inclusion, and cultural sensitivity. Information from the sessions helps APA set objectives and create programs to increase engagement of minority and underrepresented (M/UR) psychiatrists within our organization and ensure equal access to high-quality psychiatric care—health equity—for all patients regardless of race/ethnicity, age, religion, nationality, sexual orientation, gender identity, socioeconomic status, or geographical background. The event has evolved as a platform for members to increase awareness of inclusion and cultural competence and highlights diversity as a key driver of health care and institutional excellence.

Antisocial/Criminal Behavior Across the Lifespan: Inception, Implications, and Novel and Tested Interventions

Chair: Christopher R. Thompson, M.D.

Presenters: Charles Leon Scott, M.D., William J. Newman, M.D., Jessica A. Ferranti, M.D., Sherif Soliman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the theoretical underpinnings for the genesis and continuation of delinquency in youth and criminal behavior in adults (e.g., “nature” vs. “nurture” vs. both); 2) Recognize how antisocial behavior may manifest and respond to interventions differently in different age groups and genders (e.g., child, adolescent, adult, female, geriatric populations); 3) Appreciate the difficulties in and controversy around diagnosing psychopathy in different age groups (particularly children and adolescents and geriatric populations); and 4) Identify effective, evidence-based interventions for antisocial/criminal behavior in different age groups as well as more novel, but promising interventions

SUMMARY:

Juvenile delinquency and adult criminal behavior cost the United States' economy billions, if not trillions of dollars a year, both in incarceration costs and in lost productivity and human capital. For example, California's correctional budget for FY 2018-2019 alone was \$12B, and researchers have estimated that the annual cost of crime to the United States ranges from \$700B to \$3.4T. The prevention and treatment of antisocial behavior is crucially important, for fiscal, ethical, and humanitarian reasons (among others). Antisocial and criminal behavior can manifest differently at different ages, and the etiologies of and interventions for these behaviors can vary to some extent among different age groups. But as a general rule, adult criminality is almost always preceded by childhood or adolescent antisocial behavior. Researchers have proposed (and in some cases demonstrated) that there are numerous contributors to childhood and adolescent antisocial behavior, ranging from genetic predisposition, to other biological influences (e.g., prenatal exposure to stressors or toxins), to environmental influences.

Most believe, however, that a complex and dynamic interplay among these factors is responsible for the genesis and, in some cases, continuation and solidification of these behaviors. With regard to adult criminality, a fundamental challenge with treating antisocial behavior is the concept that the individuals break rules despite being fully aware of them. Various treatment approaches, both psychotherapeutic and psychopharmacologic, have been studied over the years, though with largely equivocal results. The U.K. at one point developed and implemented a Dangerous and Severe Personality Disorder (DSPD) initiative to house antisocial and psychopathic individuals in one location. However, the initiative is largely considered a failure in terms of its stated objectives. Assessing and managing antisocial women presents another unique challenge. The rate of antisocial personality disorder is lower in women than men in forensic, correctional, and community settings. Violent women are more likely to be given diagnoses of borderline personality disorder or mood disorders. Gender biases during sentencing also contribute to fewer incarcerated psychopathic women, limiting the ability to study that population. Ironically, the fastest growing population, older Americans, is the least studied with regard to criminality. By 2050, the older adult population (age 65 and older) is projected to be 83.7M, nearly double the estimated 43M in 2012. The increasing numbers of older Americans in courts and correctional institutions raises several important questions. The limited available data suggest that first time offenders over the age of 60 have a higher incidence of dementia, raising questions of competence, criminal responsibility, and mitigation. The aging prison and death row population will pose practical, financial, and humanitarian challenges for society.

Climate Change and Mental Health: Lessons Learned in Puerto Rico

Chair: David Alan Pollack, M.D.

Presenter: Carissa Cabán-Alemán, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define climate change and how it has impacted Puerto Rico.; 2) Identify challenges that underserved communities face when

confronting climate change and potential solutions to overcome these challenges.; 3) Define sociopolitical factors that can increase vulnerability to climate change.; 4) Define transformational resilience and how it can be helpful to address climate change.; and 5) Describe how community empowerment and sustainability projects can support disaster response efforts.

SUMMARY:

Numerous studies have demonstrated that the impacts of climate change are a real threat to human health. Climate change is no longer a looming threat but rather a current reality with dire consequences for humanity. Extreme temperatures, air pollution, increases in vector-borne diseases, rising sea levels, flooding, and extreme weather events are some of the key climate change impacts related to social determinants of health such as poverty, social isolation, housing instability and food insecurity. The lesser-known and often overlooked effects of climate change include impacts on mental health, such as higher rates of interpersonal violence, suicide, and diagnoses such as anxiety, depression, PTSD and dementia. The experience that Puerto Rico lived in 2017 as a result of hurricanes Irma and Maria included most of these climate change impacts and caused significant trauma. It taught invaluable lessons about how to address the social determinants of mental health in the context of a disaster and the human capacity to overcome adversity. It is also a vivid example of how systemic oppression and racism can impede the efforts of underserved communities to thrive and progress in the face of climate change, which can provide opportunities to explore how to overcome these systemic limitations. Several Puerto Rican initiatives assisted by allies in other countries addressed both the long-term consequences of the hurricanes and slow-moving recovery efforts to overcome forced migration, lost homes and jobs, closed businesses, worsening medical illnesses and higher suicide rates. These consequences became aggravated by increasingly harsh and crippling austerity measures to address a fiscal crisis that started long before the hurricanes arrived, which involves school closures, privatization policies that threaten the social safety net, loss of pensions and benefits for working citizens, rising homelessness and less access to

healthcare. This lecture will define the most prevalent effects of these challenges on the mental health of Puerto Ricans before and after the hurricanes. It will also describe how community engagement and empowerment initiatives have promoted a resilience-enhancing social system of recovery and resistance. This lecture will identify several community-based relief efforts and academic projects focused on self-sustainability that have been crucial in addressing the gaps in disaster response efforts. Furthermore, it will define transformational resilience and how it can be an effective way for underserved communities to cope with similar contexts where economic crises and/or lack of political power compound the effects of climate-related catastrophes.

Global Partnerships for Mental Health: Building Relationships and Capacity in Low-Income Settings

Chair: Geetha Jayaram, M.D., M.B.A.

Presenters: Geetha Jayaram, M.D., M.B.A., Christina T. Khan, M.D., Ph.D., Mary Kay Smith, M.D., Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss factors that have contributed to the recent increase in prioritization of mental health by global organizations and institutions; 2) Explain the benefits of addressing social determinants of health to which individuals in low-income settings are disproportionately exposed; 3) Discuss at least three approaches to developing capacity-building models that foster sustainable organizational and community capacity in low-income settings; and 4) Identify the similarities and differences among the models and approaches discussed in this session

SUMMARY:

During the past six years, mental health has become a significant priority for many global organizations and institutions. In May 2013, the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–2020, formally recognizing the importance of mental health for the World Health Organization’s (WHO) 194 member states and committing to specific actions toward improving mental health globally. Three years later, in April

2016, The World Bank Group and WHO co-hosted an event, *Out of the Shadows: Making Mental Health a Global Development Priority*, making a bold statement about the central role mental health plays in the global development agenda. The United Nations convened the First Annual Multi-stakeholder Forum on Science, Technology, and Innovation (STI) for the Sustainable Development Goals (SDGs) less than two months later, in June 2016. The initial STI Forum recognized the critical need for innovation and new partnerships in realizing the collective potential across sectors to achieve the SDGs. Even a cursory glance at the 17 goals reveals that issues impacting mental health abound. As the importance and centrality of mental health becomes apparent within and beyond the health care sector, so will opportunities for psychiatrists and other behavioral health providers to apply their knowledge and skills to meet the growing needs. Numerous opportunities exist for health care professionals to engage with existing programs and initiatives, many of which are administered through non-governmental organizations or other voluntary groups organized on a local, national, or international level. Nonetheless, many psychiatrists have forged global partnerships, one relationship at a time, to address the growing mental health burden. Through careful attention to the moral imperatives and explanatory models among cultures that differ from their own, some have been very successful in engaging local entities and establishing partnerships that incorporate the guiding values of trust, credibility, empowerment, leadership development, local ownership, transparency, and accountability. This session will explore models through which three psychiatrists, independent of one another, have forged relationships around the globe to implement effective interventions, provide education, improve access to quality health care, and address the social determinants of health to which individuals in these low-income settings are disproportionately exposed. Through innovative partnerships with local populations, they have each collaborated to develop capacity-building models that foster sustainable organizational and community capacity in low-income settings. The manner in which this occurred, one relationship at a time, will be highlighted as common themes are discussed.

Is Clinical Virtual Reality Ready for Primetime in Psychiatry?

Chair: Eric R. Williams, M.D.

Presenter: Skip Rizzo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The learner will be able to describe the definition of Virtual Reality (VR) and the different ways that people can engage and interact with VR environments.; 2) The learner will be able to explain the specific rationales for the use of VR for assessment and intervention across a wide range of clinical disorders (i.e., ADHD, PTSD, Phobias, Stroke, etc.); 3) The learner will understand the theoretical and research support for the use of VR in clinical populations.; 4) The learner will be able to discuss the relevant issues involved in the design, development, implementation, and evaluation of virtual environments for use in clinical assessment and intervention.; and 5) The learner will be aware of the ethical concerns in the clinical areas discussed along with the pragmatic issues for wide scale adoption of VR in the healthcare domain.

SUMMARY:

Since the mid-1990s, a significant scientific literature has evolved regarding the outcomes from the use of what we now refer to as Clinical Virtual Reality (VR). This use of VR simulation technology has produced encouraging results when applied to address cognitive, psychological, motor, and functional impairments across a wide range of clinical health conditions. This presentation addresses the question, "Is Clinical VR Ready for Primetime?" After a brief description of the various forms of VR technology, I will discuss the trajectory of Clinical VR over the last 20 years and summarize the basic assets that VR offers for creating clinical applications. The discussion then addresses the question of readiness in terms of the theoretical basis for Clinical VR assets, the research to date, the pragmatic factors regarding availability, usability, and costs of Clinical VR content/systems. This will be presented in the context of descriptions and video examples of applications addressing Anxiety Disorders, PTSD, Addiction, Depression, PTSD, Pain Management, Stroke, TBI, ADHD, Autism, and Virtual Human applications for clinical training and patient

facing healthcare support. Ethical issues for the safe use of VR with clinical populations will then be detailed. While there is still much research needed to advance the science in this area, I will make the case that Clinical VR applications are in fact "ready for primetime" and will soon become indispensable tools in the toolbox of healthcare researchers and practitioners and will grow in relevance and popularity in the near future as the technology continues to evolve.

Millennials and Baby Boomers: Appreciating Generational Differences in Leadership, Education, and Psychiatric Care

Chair: Jacqueline M. Feldman, M.D.

Presenters: Mary Kay Smith, M.D., Abhisek Chandan Khandai, M.D., M.S., Adrian Jacques H. Ambrose, M.D., Lee Feldman, J.D., M.A., Anna V. Davies, B.A., Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Differentiate attributes of multiple generations; 2) Compare major formative experiences, and resulting values and priorities of Millennials and Boomers; 3) Discuss strategies to leverage strengths across generations for leadership development; 4) Discuss strategies to leverage strengths across generations for approaches to education; and 5) Discuss strategies to leverage strengths across generations for approaches to clinical care.

SUMMARY:

There has been a lot of discussion about intergenerational differences, with frequent comparisons between Millennials and Boomers. Economic uncertainty from the 2007 financial crisis has contributed to Millennials' overall lower earnings, reduced assets, and diminished wealth. They are delaying marriage and childbearing, and their expectations regarding the kind of organizational culture in which they choose to work differ significantly from earlier generations. Many Millennials have grown up with access to advancing technologies and online dialogue, which they are adept at translating into action to achieve offline outcomes and results. They easily navigate disrupted commercial markets and can apply these skills and

expertise to finding innovative remedies for struggling health care systems. They appear to place a much higher value on social justice and health equity than earlier generations, and two-thirds of U.S. Millennials say that it is government's responsibility to ensure health coverage for all. It seems clear that there exist gaps in each generation's perceptions of the other's values, priorities, and commitments. Stark contrasts between Millennials and Boomers seem readily apparent, but what may appear to be generation-specific trends are sometimes found to be part of broader cultural shifts spanning multiple generations. In this context, the deliberate incorporation of all generations' values, perspectives, and expertise into organizations' strategic planning, development, and growth is paramount in making the course corrections that are necessary, particularly when we consider leadership development, approaches to medical education, and patient care in the mental health care arena. Anyone who is involved in health promotion, health care delivery, education of health care providers, or ongoing professional and personal development can do more than simply listen and react to different generations' expectations. For transformation to occur, current and future leaders need to actively integrate and leverage intergenerational strengths in order to achieve the best outcomes for all stakeholders, including health care providers. During this session, participants will explore issues of intergenerational differences in an effort to improve communication and collaboration across generations, and to arrive at possible solutions to maximize utilization of the strengths of multiple generations to facilitate leadership development, education, and patient care.

Psychiatry, Leadership, and the Urgency of the Moment in Medicine

Chair: Altha J. Stewart, M.D.

Presenters: Patrice A. Harris, M.D., M.A., Ray C. Hsiao, M.D., Claudia L. Reardon, M.D., Frank A. Clark, M.D., Dionne A. Hart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Apply quality improvement strategies to improve clinical care; 2) Provide

culturally competent care for diverse populations; 3) Identify barriers to care, including health service delivery issues; and 4) Integrate knowledge of current psychiatry into discussions with patients

SUMMARY:

Dr. Patrice Harris, a psychiatrist from Atlanta, Ga., and the first African-American woman to become AMA president when she is sworn in in June 2019, will share her personal leadership journey in medicine, including the obstacles she's overcome and lessons learned along the way. She also will share the AMA's strategic and advocacy priorities and how they relate to the practice of psychiatry, with a particular focus on achieving greater equity within the health care system, increasing physician diversity, and fighting the nation's opioid epidemic.

Psychiatry's Dark Secrets: Shadows Along American Psychiatry's Lighted Path

Chair: Mark Komrad, M.D.

Presenters: Mark Komrad, M.D., Rahn K. Bailey, M.D., David Lynn Scasta, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand that the history of Psychiatry in America has not only triumphs to celebrate but some misadventures, wrong turns, blunders and embarrassments which in their time seemed scientifically ; and 2) Learn about the Eugenics Movement in the U.S. from 1900-1940 and the role of leading American psychiatrists in the development of that movement and the deployment of the associated program to sterilize; 3) Review the way in which psychiatry understood homosexuality as a failure of normal human development which made fulfilling, normal relationships untenable – thereby creating a market for psychiatric i; and 4) Learn about the typical racist distortions in psychiatry's approach to the African American community in the scientific literature, clinical diagnostic evaluation, psychodynamic theories, and treatment

SUMMARY:

On this 175th anniversary of the APA, there is much to celebrate. However, ours is not merely a golden path of successes, but a complex

journey with some wrong turns, misadventures, embarrassments, and even catastrophic failures. It is important that we honestly reflect on that history at this anniversary time, and cast light onto some of those shadows. This symposium will present three examples of how Psychiatry has gone astray since the founding of the APA. In an era when assisted suicide and voluntary euthanasia, even of psychiatric patients, is becoming increasingly practiced, it is important to look at how Psychiatry lost its ethical moorings in the past, in the face of social pressures and “progressive ideas.” The Eugenics movement in the U.S. (1902-1939) led to forced sterilization of the mentally ill and the developmentally disabled. This program was deployed in some of the major U.S. psychiatric asylums of the time and was promoted by leaders of American Psychiatry, through as late as 1983. Those influential psychiatrists saw themselves as enlightened moral pioneers, moving their societies ethically forward. Though taken to the brink of proposing involuntary euthanasia for the mentally ill, that further step was left to the notorious T4 Program in Nazi Germany. In the mid-1900s, the APA was steeped in psychoanalysis as indisputable dogma, ignoring efforts of psychologists to bring other sciences to bear on the understanding of human behavior. American psychiatrists pathologized homosexuality as a failure of normal human development that made fulfilling, normal relationships untenable. This created a market for psychiatric interventions. Scientific studies to the contrary went unnoticed. It was a dark time for LGBTQ people who were subjected to treatments which inevitably led to failure, invariably attributed to the failure of the patient, not the therapist. Gay activists and progressive psychiatrists challenged that view in the early 70’s. When psychiatrist Dr. John Fryer told colleagues (in disguise) at an APA meeting in 1971 what it was like to be a gay psychiatrist, attitudes began to change. Now the APA is in the vanguard of advocacy for LGBTQ people. This is the story of the APA’s journey from malevolent paternalism to benevolent patronage. Racial prejudice has informed Psychiatry throughout much of the 20th Century. A 1921 article in the *American Journal of Psychiatry* described African Americans as being not very far removed from their cannibalistic and savage forefathers, and how, upon puberty,

their interests turn to the procurement of sex and vice. Psychoanalysis also had various race-based notions, claiming that African Americans may be devoid of the ability to experience loss. These and other distortions were more informed by dominant cultural trends than by science. Though corrections have been made, there may be lasting effects and perceptions which persist within our profession, and in society at large.

Shaping the Future of Psychiatry Through Research and the Delivery of Care

Chairs: Joshua A. Gordon, M.D., Ph.D., Herbert Pardes, M.D.

Presenters: Matthew Nock, Cheryl King, Kay Tye, Conor Liston, M.D., Ph.D., Alan Anticevic, Ph.D., Yael Niv

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the role of the NIMH in supporting neuroscience and psychiatry research; 2) Understand how basic and clinical approaches to examining neural circuits hold promise for advancing understanding and novel treatments for mental illnesses.; 3) Understand how basic and applied computational approaches hold promises for advancing understanding and novel treatments for mental illnesses.; and 4) Understand how basic and clinical approaches hold promises in prevention of suicide.

SUMMARY:

The National Institute of Mental Health (NIMH) is the lead federal agency for research on mental illnesses, with a mission to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. As NIMH Director, my scientific priorities include suicide prevention, neural circuits, and computational and theoretical approaches to psychiatry. These priority areas have the potential to improve clinical care over the short, medium, and long-term, respectively. This panel brings together three pairs of speakers to address each of these priority areas from the basic and the clinical perspectives. Together, we will explore advances in computing and technology to improve the understanding, prediction, and prevention of suicidal

behavior, and examine how suicide risk screening and intervention for adolescents is changing the future of clinical care. In the area of neural circuits, we will discuss how plasticity is being used as a therapeutic tool for anxiety, and hear about the sustained rescue of prefrontal circuit dysfunction by antidepressant-induced postsynaptic spine formation. Additionally, we will explore computational and theoretical approaches to map neuro-behavioral relationships linked to effects of neuropharmacology, biophysical computational models, and transcriptomic effects in humans, and learn how model behavior phenotypes can assist with diagnosis, prognosis, and tracking the efficacy of treatment.

Transcend: Lessons Learned From a Career With Twists and Turns With a Single Focus on Unmet Needs Across Industries

Chair: Mary Kay Smith, M.D.

Presenter: Gabriela Cora, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session the participant will be able to identify strategies to engage and include people on their path to wellness.; 2) At the conclusion of this session the participant will be able to identify individual talents and skills to focus on their own creativity, innovation and disruption to address unmet needs across industries; and 3) At the conclusion of this session the participant will be able to integrate communication tools to address specific needs with the public at large.

SUMMARY:

Mental illnesses are common in the United States. Nearly one in five US adults lives with a mental illness (44.7 million in 2016) as per the National Institute of Mental Health. Mental illnesses include several conditions with a wide range of severity from mild to moderate or severe depending on how they affect functioning. Women are affected more than men and prevalence is higher among adults reporting two or more races. Suicide continues to be a leading cause of death in the United States as per the Centers for Disease Control and Prevention, claiming the lives of nearly 45,000 people per year as

per 2016 reports. There are approximately 25,250 psychiatrists employed in the United States with 8,500 of them working in offices of Physicians; 3,700 in Psychiatric and Substance Abuse Hospitals; 3,500 in General Medical and Surgical Hospitals; and 3,300 in Outpatient Care Centers as per the Bureau of Labor Statistics. Most of these psychiatrists practice in New York followed by California and then Ohio, Texas and New Jersey. The BLS expects this profession to grow by 4 percent from 2016 to 2026, resulting in 3,600 new jobs. In the meantime, a systematic review published in JAMA in 2018 points to a substantial variability in prevalence estimates of burnout among physicians ranging from almost none to 80% with the additional challenge of marked variation in burnout definitions and assessment methods. It is unclear how specific career paths lead to greater professional satisfaction and less burnout. Most traditional Psychiatry options have focused on individual services addressing needs of people with mild to severe mental health disorders ranging from outpatient private practices with an integrative approach including psychotherapy and pharmacotherapy to assisting other non-physician therapists with pharmacotherapy alone. Some psychiatrists have based their practices in inner cities while others have established them in community or private clinics or hospitals. Others have opted to assist the military while enlisting, contracting as a civilian or working in the VA. Additionally, there are administrative options particularly in community or private clinics and hospitals. Some psychiatrists venture into managed care opportunities whereas others go into the pharmaceutical industry. There are additional non-traditional options for psychiatrists worth exploring incorporating business and coaching models including working directly with large employers. Last but not least, the explosion of social media and its massive use has now created a two-way channel of communication instead of a one-way path with traditional means. Direct engagement and an inclusive approach are now readily available. This will particularly affect practice opportunities for the younger generations, disrupting more traditional practices. We will review several traditional and non-traditional opportunities while focusing on unmet needs of the population at large.

Wednesday, May 22, 2019

American Indian, Alaska Native, and Native Hawaiian Mental Health: The Issues, the History, the Status

Chair: Roger Dale Walker, M.D.

Presenters: Richard Livingston, M.D., Mary Hasbah Roessel, M.D., Joel Patrick Chisholm, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Examine the historical relationship between psychiatry and Indigenous Peoples in the United States.; 2) Explore the rise and cause of chronic illnesses and the increase of morbidity and mortality in these populations; 3) Discuss examples of effective urban and rural mental health programs designed to work in these populations; and 4) Discuss recruitment, recruitment, retention and mentorship of students interested in Native mental health care

SUMMARY:

The mental health of Indigenous Peoples of North America and the Pacific has been impacted by 400 years of dominance by advancing Euro- Americans under their belief in manifest destiny and dominion by colonization and control. While early psychiatric efforts focused on social reform, geographic control, and boarding school approaches, little efforts were made to understand the specific issues of Native Mental Health. A bit later, alcoholism, suicide, violence, and depression were studied by early researchers who focused on individual problems. Currently, there are evolving approaches that focus upon chronic illnesses with community/public health approaches using integrative care models, social determinants of health, childhood self-control, PTSD treatment, and historical trauma education models. Presentations in this section will cover this history, provide "how to" information when working with Indigenous Peoples individually and within the community, and will discuss how psychiatric care is provided in both urban and rural communities. Finally, the importance of the proactive efforts to promote health care made by the American Psychiatric Association will be discussed.

Clinical Updates in Geriatric Psychiatry for the Practicing Psychiatrist

Chair: Melinda S. Lantz, M.D.

Presenters: Kecia-Ann Blissett, D.O., Ilse R. Wiechers, M.D., M.H.S., M.P.P., Alexander W. Threlfall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and understand pathways for the treatment of late-life depression; 2) Identify means to include CMS compatible documentation for use of antipsychotic agents in dementia; and 3) Identify areas for improvement in the reduction of antipsychotic use in patients with dementia

SUMMARY:

We live in a world with an increasing aging population. In the United States alone, 10,000 persons turn 65 years old every day. This increase in older adults creates a great need for clinicians who can diagnose and treat the conditions that occur among our senior most people. Disorders including Depression and Dementia create significant impact on the families and caregivers of older adults. This session will provide up to date clinical practice information on late life disorders frequently encountered by practicing clinicians and offer practice guidelines and regulatory guidance. Issue of prescribing antipsychotic medications in late life has become an extremely controversial and heavily governed issue, yet in certain circumstances is vital and life-saving. Methods and approaches to documentation and therapeutic monitoring of outcome will be reviewed. Personality disorders persist well into late life and present complex challenges to the care of older adults across medical and psychiatric settings. The clinical presentation of personality pathology in late-life, barriers to care and updates in the treatment of distressing symptoms will be reviewed. Advocacy for Geriatric Mental Health has never been more relevant or in greater need. Our political climate does not foster the degree of engagement and support that we need to grow a specialty workforce. Techniques designed to promote advocacy and partnership skills will be reviewed and discussed.

Creating a Culture of Diversity and Inclusion in the Clinical Learning Environment

Chair: Sandra M. DeJong, M.D.

Presenters: Altha J. Stewart, M.D., Robert Mark Rohrbaugh, M.D., Nicolas E. Barcelo, M.D., Shireen Cama, M.D., Hendry Ton, M.D., Adrienne L. Adams, M.D., M.S., Donna Marie Sudak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the importance of creating a culture of diversity and inclusion in the Clinical Learning Environment; 2) Describe the role of training programs in creating a culture of diversity and inclusion in CLER; 3) Appreciate the perspective of both general psychiatry residents and child/adolescent fellows on issues of diversity and inclusion based on first-hand experience; 4) Describe the roles of department, institutional and national organization leadership in contributing to a culture of diversity and inclusion in CLER; and 5) List suggestions for improving the current CLER in the future by addressing issues of diversity and inclusion

SUMMARY:

“Diversity” includes “myriad personal characteristics—e.g., race, ethnicity, culture, nationality, religion, language, sexual orientation, gender identity, age, experiences, political party affiliation, and physical abilities, among others” [1]. “Inclusion” puts “the concept and practice of diversity into action by creating an environment of involvement, respect, and connection—where the richness of ideas, backgrounds, and perspectives are harnessed to create. . . value” [2]. While the patient population in the US is diversifying, corresponding diversity among physicians, including psychiatrists, is lagging behind [3]. The racial makeup of US psychiatry residents in 2013–2014 was 50.5 % white, 26.7 % Asian, 8.3 % Hispanic/Latino, and 6.6 % black [4]. The discrepancy between patient and provider demographics persists despite evidence that improving diversity among providers improves quality and reduces disparities in patient mental health care. In psychiatry, evidence suggests that culture disproportionately impacts key aspects of care including symptom expression and attribution, care-seeking behaviors, stigma, and access to mental health services [5]. In 2009, The Liaison Committee

on Medical Education (LCME), required that “medical schools have policies and practices to achieve appropriate diversity among its students, faculty, and staff, and other members of its academic community, and . . . engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.” Recently the Accreditation Council for Graduate Medical Education (ACGME) added a similar requirement, in addition to requiring residents show “sensitivity and responsiveness to . . . diversity in gender, age, culture, race, religion, disabilities, and sexual orientation” [Professionalism, ACGME CPRs IV.A.5.e).(5)], and that they “receive training and experience in . . . understanding health care disparities” [VI.A.1.b).(1).(a) https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf]. Creating a culture of diversity and inclusion is intimately linked to recruitment and retention of “Under-Represented in Medicine” (URM) trainees and faculty [6]. Resolving this conundrum requires a systemic, multi-stakeholder approach. This symposium seeks to represent many of these stakeholders—training directors and trainees, department, medical school and institutional leaders, and national psychiatric organizations--so that each can describe their potential role in improving the culture of diversity and inclusion, enhancing recruitment of URMs, and improving mental health care disparities and patient care. Current and recent trainees will share their first-hand experience. APA President Altha Stewart and AADPRT President Donna Sudak, who recently appointed the first AADPRT Committee on Diversity and Inclusion, will open and close the session.

Is It Burnout, or Is It Arson? The Impact of Organizational Culture on Physician Well-Being

Chair: Mary Kay Smith, M.D.

Presenters: Mary Kay Smith, M.D., Carol Ann Bernstein, M.D., Joseph Zumpano, J.D., M.P.H.

Discussants: Altha J. Stewart, M.D., John S. McIntyre, M.D., Carol Ann Bernstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss similarities and

differences in the major initiatives aimed at reducing burnout and improving well-being among medical students, residents, and physicians; 2) Explain how an integrated cultural framework can be used to better understand key attributes of an organization's group culture and individual leadership styles; 3) Summarize a model to explain how an organization's internal conflicts, dissensions, quarrels, and rivalries might lead to restoration of group harmony at the expense of an individual's well-being; 4) Explain the importance of alignment between an individual's values and priorities and those of the workplace or organization; and 5) Summarize five issues, including at least one recommended action for each, that need to be addressed in order to ensure a more intentional, inclusive pursuit of physician well-being

SUMMARY:

As the literature on clinician well-being continues to grow and recommended interventions are enacted, a central issue related to burnout is getting little attention: In some health care systems and institutions, the organizational culture is permitting, and at times causing, harm. Individuals experiencing this are not confined to a particular stage of professional development and do not share a single identity, though previous experience with structural discrimination is common. These behaviors may be unintentional, deliberate, or somewhere in between, but individuals who experience them are negatively impacted, regardless. With heightened awareness of clinician burnout and its inextricable relationship to mounting problems in U.S. health care, one might ask, "Is it burnout, or is it arson?" In 2008, the Triple Aim challenged health care organizations to optimize their performance by enhancing the patient experience of care, improving the health of populations, and reducing per capita costs. Further recognition of the need to improve the work life of health care providers and staff to achieve this optimal performance transformed the Triple Aim into the Quadruple Aim, reinforcing the growing awareness of burnout among health profession learners and clinicians. In their 2018 report, *Psychiatrist Well-being and Burnout*, the APA Board of Trustees Work Group on Psychiatrist Well-being and Burnout concluded, in part, that burnout "...is best addressed as a systemic problem with systemic interventions directed at changes in the workplace.

These interventions include those targeting workflow, autonomy, isolation, communication and teamwork." Recommendations for systemic interventions commonly contain an implicit assumption that organizations and will be willing partners in creating a workplace that is more conducive to clinician satisfaction and fulfillment than to burnout. While it is necessary for leaders to examine and understand the dimensions of institutional culture when attempting to change it, it is important for individuals to examine their ongoing 'fit' within the institution's tacit social order. When aligned with personal values, needs, and priorities, a shared sense of purpose can lead to extraordinary accomplishments and a healthy environment in which to learn and work. When alignment is lacking, however, individuals outside the accepted group norms may find themselves increasingly marginalized, or worse. Participants will be actively engaged during this symposium as presenters review national initiatives aimed at reducing burnout and enhancing well-being; examine how institutions with unresolved, internal conflicts can harm select individuals; and explore the importance of alignment between organizational culture and personal values, needs, and goals. Two former presidents of APA will join Dr. Stewart in discussing key issues to be addressed in pursuit of a more inclusive approach to physician well-being.

Latinos in 2019

Chair: Rodrigo A. Munoz, M.D.

Presenters: Renato D. Alarcon, M.D., Bernardo Ng, M.D., Eugenio M. Rothe, M.D., Christina V. Mangurian, M.D.

Discussant: Theresa M. Miskimen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recount the evolution of Latino psychiatry; 2) Evaluate present progress and challenges; and 3) Present conflicts and opportunities

SUMMARY:

Active participation in APA activities started for Latinos in the 1960's in an atmosphere of activism for better representation, more awareness of civil rights and ambition for recognition and equality.

Demographic growth in the 1980's did forecast that Latinos would become a major force in the country, specially in states like California and Texas, and cities like Chicago and New York. Today we enjoy in academia, and líderes in clinical practice, in professional institutions and in the APA. The presentations here elaborate on the lessons we can learn from our current experiences to assure a better future for the Latinos.

Special Sessions

Saturday, May 18, 2019

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

Faculty: Lori E. Raney, M.D., Ramanpreet Toor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part

of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project.

MindGames Resident Competition

Hosts: Art C. Walaszek, M.D., Tristan Gorrindo, M.D.

Moderators: Richard Fredric Summers, M.D.,

Michelle B. Riba, M.D., M.S., Marcia L. Verduin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate knowledge of current psychiatry into discussions with patients; 2) Describe new research findings in psychiatry and neuroscience and how they may impact practice; and 3) Describe the utility of psychotherapeutic and pharmacological treatment options

SUMMARY:

MindGames is the American Psychiatric Association's premiere head-to-head educational challenge on patient care, medical knowledge, and the history of psychiatry. The game is executed in a Quiz Bowl format where three teams of three contestants are presented with psychiatric knowledge-based clues in the form of answers. MindGames is hosted by Dr. Art Walaszek and will feature three resident teams. Each team must first pass a qualification round; the top three performing teams from the qualification round will go on to compete in the live event.

MindGames: 175th Anniversary Edition

Hosts: Art C. Walaszek, M.D., Tristan Gorrindo, M.D.

Moderators: Richard Fredric Summers, M.D.,

Michelle B. Riba, M.D., M.S., Marcia L. Verduin, M.D.

Presenters: Albert C. Gaw, M.D., John S. McIntyre, M.D., Jeffrey Lee Geller, M.D., M.P.H., Theresa M. Miskimen, M.D., Roger Dale Walker, M.D., John A. Talbott, M.D., Geetha Jayaram, M.D., M.B.A., Rahn K. Bailey, M.D., Roger Peele, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the utility of psychotherapeutic and pharmacological treatment options; 2) Identify barriers to care, including health service delivery issues; and 3) Integrate knowledge of current psychiatry into discussions with patients

SUMMARY:

MindGames is the American Psychiatric Association's premiere head-to-head educational challenge on patient care, medical knowledge, and the history of psychiatry. The game is executed in a Quiz Bowl format where three teams of three contestants are presented with psychiatric knowledge-based clues in the form of answers. This 175th anniversary edition of MindGames features clues on the history of psychiatry and the APA. MindGames is hosted by Dr. Art Walaszek and will feature three expert teams: Dorothea Dixiforimidables, Walk in Beauty, and Comeback Kids.

Sunday, May 19, 2019

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

Faculty: Mark H. Duncan, M.D., John Sheldon Kern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project.

Monday, May 20, 2019

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

Faculty: Anna Ratzliff, M.D., Ph.D., John Sheldon Kern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3)

Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project.

Tuesday, May 21, 2019

Applying the Integrated Care Approach 201: The Advanced Course in Collaborative Care

Faculty: John Sheldon Kern, M.D., Anna Ratzliff, M.D., Ph.D., Mark H. Duncan, M.D., Doree Ann Ventura-Espiritu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the most important tasks required for successful implementation of a collaborative care program; 2) Describe the use of collaborative care payment codes; and 3) Demonstrate registry data evaluation and use in collaborative care

SUMMARY:

In the last two years, the APA / AIMS Center Support and Alignment Network (SAN) project has trained over 3,200 psychiatrists in the Collaborative Care model to provide behavioral health services in the primary care setting. Most of these psychiatrists received their training in in-person presentations at live District Brand or APA meetings. Many of the psychiatrists have gone on to be involved in successful implementations of the Collaborative Care model, and many more are preparing to do so. So far there have been 25 completed SAN learning collaboratives, an advanced online training activity. There continues to be strong interest among participating psychiatrists in ongoing support and training in Collaborative Care, and this workshop will present the opportunity for exposure to advanced topics in Collaborative Care. We will discuss a number of areas crucial to the successful implementation of Collaborative Care programs, including an up to date review of the new CMS payment codes for Collaborative Care, an update of recent Medicaid and private payor rollouts and a thorough introduction to the APA / AIMS Center Financial Modeling Tool, that has been assisting organizations with making credible financial plans for Collaborative Care implementation. Two organizations who have successfully implemented Collaborative Care programs will present their experiences, with a focus on those issues most critical to successful roll-out. Finally, there will be a review of techniques and strategies for efficiently training members of the Collaborative Care team, including care managers and PCP's. There will be opportunity for participants to engage with panel members in order to reflect the diverse real-life

experiences of building and implementing a Collaborative Care program.