

IPS 2019

THE MENTAL HEALTH
SERVICES CONFERENCE

IMPROVING
ACCESS
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**INNOVATION &
COLLABORATION**

Syllabus and Proceedings



AMERICAN
PSYCHIATRIC
ASSOCIATION

Courses

Thursday, October 03, 2019

Buprenorphine and Office-Based Treatment of Opioid Use Disorder

Director: John A. Renner, M.D.

Faculty: Petros Levounis, 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 protocols of treatment for buprenorphine and other forms of MAT and protocols for optimal patient/treatment matching; 4) Describe the legislative, logistical 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:

The course will describe the resources needed to set up office-based treatment with buprenorphine and naltrexone for patients with opioid use disorder and will review: - DSM-5 criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD - Confidentiality regulations related to treatment of substance use disorders - Drug Enforcement Administration requirements for prescribing opioids for the treatment of OUD and for record keeping - Staffing requirements, billing and common office procedures - The epidemiology, symptoms and current treatment of anxiety, common depressive disorders, ADHD, and how to distinguish independent psychiatric disorders from substance-induced psychiatric disorders - Common clinical events associated with addictive behavior, including relapse, medication diversion and disruptive behavior Special treatment populations, including adolescents, pregnant women, and geriatric, HIV positive patients and chronic pain patients will be addressed and small-group case discussions will be used to reinforce learning References.

Suicide Prevention Through the Public Health Lens: Assessment of Risk, Intervention, and Monitoring with the Essential Clinical Tool Kit

Director: Kelly Posner, Ph.D.

Faculty: Kseniya Yershova, M.D., Christa Labouliere, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the scope of suicide as a public health crisis and rationale for the new public health model of suicide prevention; 2) Demonstrate knowledge of the Columbia Suicide Severity Rating Scale (C-SSRS) as the suicide risk assessment tool and improve suicide risk assessment skills; 3) Identify the main components of the Safety Plan intervention and able to apply it in practice; and 4) Recognize the primary barriers to effective assessment and treatment of suicidal patients in own practice and apply new methods for surmounting these barriers in practice.

SUMMARY:

This course will open with the examination of the current paradigm shift in our approach to suicide prevention – out of psychiatry and into public health. Suicide rates are increasing virtually in every demographic group and as shown by every major suicide prevention initiative (e.g., WHO 2014, CDC 2011) these trends can only be reversed with interdisciplinary and cross-sectoral collaboration. For this to happen, we need portable and universal tools for assessment, risk mitigation and attitude change. The Columbia Suicide Severity Rating Scale (C-SSRS, Posner et al 2011) has emerged as a simple and effective suicide risk assessment tool that is now deemed the most-evidence supported tool of its kind. It has demonstrated ability to detect high risk and provide guidance for next steps using evidence-based thresholds. This allows us to decrease unnecessary interventions, redistribute resources based on clinical need, and expedite care delivery. All gatekeepers (e.g., schools, first responders, corrections, hospitals/behavioral health) can use the tool, which enables us to find those at-risk in their communities. This portability is also essential for linking of systems and integration of care. The C-SSRS is breaking down the barriers like stigma and

fear of liability. Numerous states and countries have moved towards system-wide implementation of the tool. Participants will learn the rationale for this risk assessment model, the tool's structure and guidelines for triage and care delivery. Across many public health settings, the Safety Plan intervention (Stanley & Brown, 2012) has become the first-line treatment for those with current suicidal thoughts. It is a written, prioritized list of coping strategies and resources to provide those experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behavior. The Safety Plan intervention is a collaboration between a clinician and a patient. Participants will learn the rationale and administration of Safety Plan using clinical demonstration. The success of redesigning processes of care and wide adoption of new tools depends on changing perceptions and attitudes. The course will delve into specific barriers to assessment and treatment engagement (e.g., patient non-disclosure) and factors that facilitate overcoming these barriers. Using clinical examples special attention will be given to unpacking stigma and relational mechanisms that drive attitude change. Case illustrations will be used to demonstrate how understanding and laying these factors as a foundation for suicide prevention leads to successful programs and when these factors are discounted, even with the best intentions, certain suicide prevention strategies do not work or are even harmful (e.g., use of seclusion).

Friday, October 04, 2019

**All You Ever Wanted to Know About Clozapine:
Basics and Beyond**

Director: Robert Osterman Cotes, M.D.

Faculty: Deanna Kelly, Pharm.D., Anthony S. Battista, M.D., M.P.H., Jose De Leon, M.D., Sarah Debrey, M.D., M.H.S., Frederick C. Nucifora Jr., D.O., Ph.D., M.H.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe two hypotheses as to why clozapine has a unique efficacy; 2) Deliver an "elevator speech" for their patients on why to consider clozapine; 3) State three benefits of using clozapine levels; 4) List and describe strategies to

mitigate the most common serious side effects of clozapine including neutropenia and myocarditis; and 5) Define ultra-treatment-resistant schizophrenia and list three proposed interventions for these individuals.

SUMMARY:

One study estimated that Treatment Resistant Schizophrenia adds 34 billion dollars a year in direct medical costs in the US. Clozapine is the only medication that is approved by the US FDA for Treatment Resistant Schizophrenia. As many as 20-25% of individuals with schizophrenia may meet criteria for treatment resistance, yet clozapine remains highly underutilized in the US in comparison to other countries. Some of the barriers to clozapine's use include weekly blood work, coordination with pharmacies, the potential for multiple side effects, and prescriber lack of knowledge. Psychiatrists working in community mental health settings are likely to routinely encounter individuals who may benefit from clozapine. This course seeks to increase the participant's comfort on clozapine, and has been developed for clozapine prescribers of all levels. Divided into 25-minute rapid-fire talks (with five minutes for questions after each session), the presenters will provide a state-of-the-art update of clozapine's unique pharmacology, indications, and management of side effects (including neutropenia and myocarditis). This course will also help the participant fine-tune approaches for how to talk to a patient about clozapine, utilize clozapine levels, and how to deliver services that could help to facilitate clozapine's use. Finally, we will provide some suggestions of pharmacological and psychosocial interventions for how clinicians can help their patients who have persistent positive, negative, and/or cognitive symptoms despite taking clozapine.

Marijuana and Mental Health

Director: Thida Myo Thant, M.D.

Faculty: Erica Kirsten Rapp, M.D., Jesse Darrell Hinckley, M.D., Ph.D., Alexis D. Ritvo, M.D., Helena Winston, M.D., Andrew Kluemper

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify various dispensary and

pharmaceutical formulations of medical marijuana; 2) Review the latest literature on how cannabis use impacts psychiatric illnesses including mood disorders, anxiety and psychosis; 3) Recognize the short and long term effects of cannabis use in adolescents; 4) Understand differences between some medical marijuana programs as well as the current state and implications of current legislation; and 5) Know treatments for acute cannabis intoxication and cannabis use disorder.

SUMMARY:

Marijuana use is a controversial topic across the United States. Opinions about marijuana can range from it being a harmless natural plant with medicinal value while others view it as a substance of abuse with overstated benefits and understated risks. Despite the classification of marijuana on a federal level, marijuana use is becoming legalized by states across the U.S. and highlights the ambivalence about marijuana in our society. Research currently suggests increased teenage and adult use of marijuana in states with legalized medical marijuana with noted harmful effects for adolescents and those with psychotic spectrum disorders. With the increasing prevalence and availability of marijuana products, medical providers will need to become more informed and well versed about marijuana beyond the scope of addiction. This workshop will familiarize attendees with this new culture of legalized medical marijuana and its implications for psychiatry. This 4 hour "Marijuana and Mental Health" course will feature presentations on: (1) Medical marijuana, including pharmaceutical and dispensary formulations, brief overview of the relevant neurobiology, efficacy in treating mental health conditions, dosing, interactions and monitoring and psychiatric complications of cannabis use, including impact on anxiety and mood disorders; (2) marijuana and psychosis; (3) short- and long-term effects of cannabis use in adolescents; (4) the treatment of cannabis use disorder, including psychotherapeutic and pharmacologic interventions; and (5) legislation and policy related to medical marijuana. Presentations will feature audience participation, case examples and will end with a panel discussion on the ethics of marijuana in medicine. Participants will hear the latest literature and updates on marijuana, receive tips on how to discuss this

information with their patients and learn ways to manage the effects of marijuana use in their clinical practice.

Saturday, October 05, 2019

Controversies in Adult Psychopharmacology

Director: Joseph F. Goldberg, M.D.

Faculty: Shari Isa Lusskin, M.D., Carrie L. Ernst, M.D., Stephen Ross, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain risks associated with psychiatric illness in pregnancy for the developing baby and devise risk-benefit analyses for the use of psychotropic medications in pregnancy; 2) Assess risks and benefits of psychotropic medications in patients with cardiovascular and other serious medical conditions; 3) Describe indications, risks and benefits for the psychotherapeutic use of classic hallucinogens for affective and addictive disorders; and 4) Explain clinical characteristics that favor or discourage the safety and efficacy of antidepressants in the treatment of bipolar disorder.

SUMMARY:

Optimal pharmacotherapy strategies are not well-established for a number of adult psychopathology presentations. For some conditions, such as bipolar depression or treatment-resistant mood disorders, consensus is lacking even among experts about the potential benefits versus detriments of monoaminergic antidepressants, and when to pursue instead novel therapeutics. The FDA's approval of esketamine for treatment-resistant depression, alongside a growing treatment database with intravenous ketamine, has occurred amid renewed interest in the potential psychotherapeutic benefits of other scheduled compounds such as serotonergic hallucinogens. Many practitioners seek more familiarity with data on the psychotropic risks and benefits of lysergimides, tryptamines, and phenethylamines in order to demystify misconceptions, make more informed treatment decisions, and provide up-to-date patient counseling about benefit versus harm. Even traditional pharmacotherapies for mood, anxiety or psychotic disorders are subject to unique controversies

regarding safety and efficacy within specific clinical populations, such as patients with bipolar disorder, during pregnancy, or among those with medical comorbidities. Decision-making about treatment risks and benefits even with traditional pharmacotherapies for mood, anxiety or psychotic disorders often become more ambiguous and controversial in the setting of unique medical contexts, such as during pregnancy or nonpsychiatric medical illnesses. This course will address four major controversies in adult psychopharmacology: (a) the use of antidepressants in bipolar disorder, (b) the role of psychedelic and cannabinoid compounds for treatment-resistant mood or anxiety disorders, (c) considerations regarding antidepressants, antipsychotics, and mood stabilizers during pregnancy with respect to the presence or absence of risks for anatomical or behavioral teratogenicity, and (d) safety and efficacy concerns when using antidepressants and antipsychotics in the medically ill. Presentations will familiarize attendees with pertinent clinical trials literature and focus on helping them reason through the elements of risk-benefit analyses to identify appropriate pharmacotherapies for distinct clinical populations. A key concept shared throughout all presentations will be the notion of relative versus absolute clinical contexts; that is, psychotropic compounds may exert beneficial or detrimental effects depending on where, how, and for whom they are utilized. Attendees will understand the circumstances under which the psychotropic properties of a given agent conform favorably or adversely to the profile of a given patient in light of their individualized medical and psychiatric vulnerabilities.

General Sessions

Thursday, October 03, 2019

2019 Psychiatric Services Achievement Award Winners: Innovation in Service Delivery

Chair: Bruce Jan Schwartz, M.D.

Presenters: Sagar V. Parikh, M.D., Stephanie Salazar, M.P.H., Todd Archbold, Joshua David Stein, M.D., Ole J. Thienhaus, M.D., Lori Wellman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize creative models of service delivery and innovative programs for persons with mental illness or disabilities; 2) Celebrate the 2017-2018 recipients of the Psychiatric Services Achievement Awards; and 3) Highlight best practices from award recipient programs.

SUMMARY:

Since 1949, the Psychiatric Services Achievement Awards have recognized creative models of service delivery and innovative programs for persons with mental illness or disabilities. This year, APA is pleased to announce the recipients of the 2019 awards: Gold Award (academic program): Michigan Peer to Peer Depression Awareness Program - Lizelle Salazar, MPH - Stephanie Salazar, MPH Gold Award (community-based program): Psychiatric Assistance Line - Todd Archbold, LSW, MBA - Joshua D. Stein, MD Silver Award: The Whole Health Clinic - Ole J. Thienhaus, MD - Lori Wellman, MC,NCC

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.

Doctors' Mental Health and Well-Being

Chair: Dinesh Bhugra, M.D.

Presenters: Andrew Grant, Ph.D., M.B., B.S., Thomas C. R. Wilkes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be aware of rates of disorders among medical students and doctors; 2) Become aware of causative factors; 3) Learn about what is needed at institutional level; and 4) Learn about how to look after their own mental health.

SUMMARY:

One of the most stressful professions is that of medicine where doctors have to make life or death decisions on a regular basis. Medical students are also faced with stress related to technical advances in medicine. There is no doubt that by and large, doctors are dedicated professionals who wish to provide the best care possible to their patients. But at any one time, a proportion of the medical workforce must also manage a diagnosed mental health condition of their own. Mental health is not static; it can deteriorate but it can improve too and there are opportunities for doctors to learn from and support each other through their own experience. Experiencing poor mental health should not be associated with failing as a doctor. Surveys have shown that the working environment has an impact on doctors such as long hours worked add to feeling tired and stressed leading to emotional disturbance. The mental health of the workforce needs further support at policy, national, institutional and personal levels. Doctors should have rapid access to support as and when they need it. Differing patterns of access and service use are reported across different grades. Internal and external stigma can play a role. In this talk, findings from a recent survey of medical students and doctors will be described and suggestions made in order to reduce morbidity.

Most doctors receive offers of support when referred to occupational health or requesting support, but this is not the same for everyone. Medical students and trainee doctors report high rates which is not surprising because they are in the vulnerable age group when psychiatric disorders start.

Exploring Our Multiple Identities as Psychiatry Residents

Chair: Xinlin Chen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) - Reflect upon our individual cultural backgrounds and identities as psychiatry residents; 2) - Identify power relations within psychiatric settings which affect both clinicians' provision of services and patients' utilization of mental health treatment; and 3) Discuss challenges regarding issues of culture and difference in residency training.

SUMMARY:

Psychiatry residency is a time of great development and change, not only due to the volume of learning, but also due to finding our place within the culture of psychiatry. Residency is a time of personal and professional growth, as we integrate our new professional identities with other aspects of our life histories. This includes our multicultural identities and ethnic backgrounds, which might not always have opportunities to be freely expressed within psychiatry training or in supervision. Yet, when psychiatrists and patients meet in a cross-cultural encounter, each brings aspects of our multiple identities to the treatment dyad. Furthermore, roles of psychiatrist and patient are not static as many residents might navigate our own histories of psychiatric treatment and lived experience with mental illness. For those of us from communities of color, LGB/T/gender non-conforming communities, immigrants, and/or differently-abled, entering the field of psychiatry can be especially complex both in our relationships with our patients and in our interactions with supervisors. Opportunities to process these experiences and promote awareness of our own identities as psychiatric residents and clinicians are crucial towards improving the

therapeutic process for patients, and increasing cultural and structural awareness within our institutions. This workshop is a novel peer-led experiential group process with the goal of developing sensitivity to our identities as psychiatric residents. The goal is to promote reflection and cultural awareness. This workshop utilizes a multidimensional model of identity and emphasizes structural power imbalances. It was developed following a literature review of similar trainings and has been modified based on past iterations with psychiatry residents in various residency programs and conferences. The workshop starts with participants agreeing to a group frame that allows for confidentiality and mutual respect. The discussion proceeds through a series of questions inviting personal reflection on identity, power imbalances, and mutual support around difficult clinical or supervisory scenarios. This project adds to the existing literature, which mostly focuses on cultural competency towards patients and currently does not describe any peer-led group process centering psychiatrists' cultural identities. Through this workshop, participants will reflect on our various identities as they relate to our profession, towards improved patient care and equity within our field.

Improving Access to Care: Co-Response Teams—an Innovative Partnership Between NYPD and the NYC Department of Health and Mental Hygiene

Chair: Joy Kang, Ph.D.

Presenters: Terri Tobin, Ph.D., Aman Nakagawa, L.M.S.W., M.S., Iva Magas, M.A., M.Sc., Michelle Pelan, L.M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the operations of an innovative law enforcement-behavioral health pre- and post-crisis program in NYC.; 2) Describe challenges and lessons learned from the first two years of Co-response team (CRT) program implementation.; 3) Understand program implementation and initial outcomes using data collected from the first two years of the program.; and 4) Provide real-life CRT case examples to engage audience in thinking through the challenges of this program..

SUMMARY:

Police departments around the country, including the New York Police Department (NYPD), are often placed in roles they are ill-equipped to manage. This is true of their being tasked with assisting people with mental health, substance use, and/or other social needs who are at risk to themselves or others. In 2017, there were close to 169,000 mental health calls to New York City's 911 Communications Division. Co-Response Teams (CRT) is a NYPD/New York City Department of Health & Mental Hygiene (DOHMH) program comprised of clinical and law enforcement response teams jointly engaging people with mental illness and/or substance use, identified as having escalating behaviors and increasing risk to themselves or the community. CRT is a pre and post crisis program (with plans to pilot a direct 911 crisis response) in cases with a public safety component, formerly handled solely by law-enforcement or emergency medical services (EMS). Each Co-Response Team consists of one mental health clinician and two NYPD officers. CRT's intervention is a short-term, high-intensity engagement providing crisis management, de-escalation, brief counseling, and connection to care. The aims of CRT are to increase individuals' connections to care and services, reduce psychiatric hospitalizations, and to reduce harmful behaviors (violence, self-harm, and substance use) that may lead to incarceration. CRT serves individuals with behavioral health issue(s) and an identifiable emerging risk for violence. Since its inception in 2016, CRT has received over 1,700 referrals from NYPD precincts, city agencies (such as the Department of Homeless Services) and community-based organizations. In this session, we will discuss the role of CRT in the intersection of the criminal justice and mental health systems in NYC and speak to the successes and challenges of this new model of service. Additionally, we will examine data from the first two years of program implementation as well as preliminary data on outcomes for individuals who participated in the CRT program. CRT program staff will share real-life examples of cases to discuss with the audience the unique day to day operations and challenges of this program.

In the Shadow of History: The LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) Psychiatric Experience

Chair: Howard Charles Rubin, M.D.

Presenters: Adriana De Julio, M.D., M.S.P.H., Harshit Sharma, Amilcar A. Tirado, M.D., M.B.A., Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how LGBTQ affirmative psychiatry has evolved for both patients and practitioners over the past 50 years; 2) Discuss the importance of the DSM and the role of APA in changing outlooks globally; 3) Identify resources that address the health needs of LGBTQ service members and veterans; and 4) Understand how same sex IPV among is both similar and different from IPV in heterosexual couples and screen more for IPV without basis for the patient's gender and/or sexual orientation.

SUMMARY:

This general session presents diverse perspectives on the history of LGBTQ affirmative psychiatry. We will discuss the emergence of our medical professionals and explain how treatment of our LGBTQ patients has changed. Dr. Saul Levin, originally from South Africa, and currently Medical Director and CEO of the American Psychiatric Association (APA) will describe how, in the struggle for LGBTQ rights, psychiatrists and the APA have stepped up to advance civil and social rights of the LGBTQ community. He will share the story of John Fryer who challenged the prevailing dogma of homosexuality as mental illness by speaking out as an openly gay psychiatrist. Dr. Harshit Sharma is a recent medical school graduate and is currently applying for psychiatric residency. He will discuss the history of LGBTQ mental health in India including the negative effect of colonial era legislation and its detrimental effects on mental health. He will also discuss changes in the policies of Indian Psychiatric Society and in the attitudes of Indian American psychiatrists. Dr. Adriana de Julio is a Major in the US Army and out as bisexual. She completed fellowship at Massachusetts General Hospital in Neuropsychiatry. She is Navajo. She will discuss the history of the Don't Ask Don't Tell mandate and its

discontinuation. She will also address issues around integration of transgender military members and the current administration's instructions to dismiss transgender service people. Dr. Amilcar A. Tirado, a Puerto Rican psychiatrist who is currently an Assistant Professor of Clinical Psychiatry at Weill Cornell Medical College, will discuss the medical and mental health impact of intimate partner violence (IPV) on LGBTQ couples. He will explore issues and challenges that LGBTQ communities have when attempting to report an incident of IPV and to access services. Dr. Howard Rubin, Director of the Medical Student Well-Being Program and Associate Clinical Professor at the University of California, San Francisco, will describe the LGBTQ medical and psychiatric experience over the past thirty years through the frame of personal reflections on coming out as gay in medical school and psychiatric residency in the late 1980s and early 1990s and then on working as an out gay psychiatrist and faculty member.

Innovating Access to Culturally Competent Mental Health Care for Immigrant Communities

Chair: Francis G. Lu, M.D.

Presenters: Melanie Scharrer, M.D., Evan Joshua Trager, M.D., Emily Hall, M.D.

Discussant: Rahn K. Bailey, 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 appreciate the range of approaches towards cultural integration, from culturally antagonistic to culturally driven models of care.; 2) At the conclusion of this session, the participant will be able to identify unique concerns facing immigrant families in mental health care; 3) At the conclusion of this session, the participant will understand cultural concepts of distress and demonstrate an appreciation of their use in clinical evaluation.; 4) At the conclusion of this session, the participant will better understand the connection between trauma, adverse childhood events, and substance use behaviors in immigrant communities.; and 5) At the conclusion of this session, the participant will be able to provide examples of effective community approaches addressing the needs of immigrant patients with mental illness..

SUMMARY:

This session intends to improve attendee's understanding of adapting models of care to immigrant communities via an interactive workshop including case examples, investigation of intergenerational epidemiological data, and open discussions. Immigration has been increasingly a focus of the media and political dialogues. Immigrants and their families face unique challenges in the wake of migration, coupled with inadequate resources to address their needs. Immigrant communities experience multiple barriers to care including fear of deportation and ICE brutality, language barriers, pressures to adapt or assimilate, intergenerational conflicts within communities, and sequelae of individual and collective trauma. Racial and cultural biases can increase the likelihood that patients will receive inadequate care, lacking in compassion and understanding. There is a sparsity of literature relating to mental health and substance use among refugee populations. While most reports agree that relocated individuals are at higher risk relative to the general population, challenges including heterogeneity of exposures, resettlement locations, and difficulties with accessing care limit the generalizability of the available literature. Using the existing literature, we will explore the connection between ACEs & adult trauma and substance use in immigrant populations. We will also present new data on substance use and trauma exposures in three generations of ethnic Hmong individuals settled in Wisconsin and discuss more broadly how difficulties related to acculturation and intergenerational differences may play into the identified differences between generations born in Laos, refugee camps, and in America. We will discuss strategies for engaging with adolescents and young adults from these populations in a culturally competent manner. Psychiatrists and medical providers play an essential role in addressing disparities in immigrant communities and treating the mental illnesses to which these communities are particularly vulnerable. Current efforts to provide community mental health care to immigrants include education of trainees, increasing interest in collaboration in culturally-driven care models, addressing biases, and reducing linguistic and cultural barriers to care between the medical

community and immigrant patients. UC Davis's emeritus professor of cultural psychiatry, Dr. Francis Lu, will Chair the session and the president of NMA and Chair of the Cobb Institute, Dr. Rahn Bailey will be a discussant. If available, UW's addiction psychiatry fellowship director, and PI on the Hmong Generational Health Study, Dr. Dean Krahn, will also join as a discussant.

Locked Up: What Patients With Serious Mental Illness Are Arrested for and Charged With and What Psychiatrists Can Do About It

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

Presenters: Luca Pauselli, M.D., Stephanie Langlois, Oluwatoyin Ashekun, M.P.H., Adria Zern, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide background on the over-representation of individuals with serious mental illnesses in criminal justice settings; 2) Describe pre-arrest jail diversion interventions already available and potential new forms being developed and studied; and 3) List the specific misdemeanor charges that are over-used and approaches to reducing that over-use.

SUMMARY:

Excessive criminal justice involvement among individuals with serious mental illnesses (SMI) receiving services in public-sector settings represents a failure of the mental health system and criminal justice system, especially when arrest is used to respond to situations not necessarily related to criminal behavior. The perception that this population gets arrested for "petty crimes," usually misdemeanors, has never been confirmed in a systematic study that looks at arrests and charges in people with SMI. We investigated this through two quantitative analyses with the aim to have an in-depth characterization of arrests and charges in this population. Law enforcement, clinicians, and patients are seeking alternatives to incarceration and to address the limited options available to officers during encounters with individuals with signs of SMI. The predominant form of pre-arrest jail diversion is the Crisis Intervention Team which offers self-selected officers 40 hours of training provided by police trainers, local mental health professionals,

family advocates, and patients. These officers are then specialized, first-line responders for calls involving persons in crisis. Our team developed a novel approach to pre-arrest jail diversion called "The Police-Mental Health Linkage System." After a pilot study to assess feasibility and acceptability of the intervention, we are currently studying its effectiveness with a NIMH-funded randomized trial. If effective, this intervention has the potential to have large scalability because of the low cost and easy implementation. In order to address the clinical/public health burden of mental health involvement in the criminal justice system, it is fundamental to have a better understanding of the dynamics underpinning "discretionary" misdemeanor arrests. This lays the foundation for collaborative approaches to reducing unnecessary arrest and incarceration.

Maximizing the Chances That Effective Cardiovascular Risk Reduction Interventions Are Accessible to Individuals With SMI

Chair: Corinne Cather

Presenters: Lydia A. Chwastiak, M.D., M.P.H., Gail Daumit, M.D., Kristina Schnitzer, M.D., A. Eden Evins, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide an overview of factors contributing to medical comorbidity and early mortality among individuals with severe mental illness; 2) Review design and outcomes of CVD risk reduction studies conducted by presenters; and 3) Through audience discussion determine the most important outcomes to demonstrate with CVD risk reduction interventions in order to promote access to these interventions in real-world behavioral health.

SUMMARY:

The lifespan of individuals with SMI is shortened by 25 years, primarily due to CVD. Twenty percent of those with SMI have diabetes and over half smoke tobacco, major drivers of CVD mortality. We will present the design and results from studies conducted in behavioral healthcare settings aimed to decrease CVD risk. We will discuss barriers and facilitators of implementing these interventions in

real-world behavioral healthcare settings and will elicit audience feedback on this issue. Study 1, the IDEAL trial, randomized 269 participants with SMI and at least one CVD risk factor to participate in either an 18-month multi-component intervention delivered by health coach and study nurse or to usual care. At baseline, mean(SD) age was 48.8(11.9) years. Of 269, 51% smoked tobacco, 53% had hypertension, 35% had diabetes, and 65% had dyslipidemia. Mean(SD) baseline global Framingham Score was 12.1(12.1)% overall. Trial results will be presented. Study 2 evaluated a 16-week group diabetes self-management intervention in 62 participants with comorbid SMI and diabetes. Modified intent to treat analysis of 41 individuals who attended at least one group revealed a mean 0.34 decrease in HbA1c ($p=0.04$) over the intervention period. For patients who completed more than 5 sessions ($n=30$), a mean decrease in HbA1c of 0.47 ($p=0.03$) was observed. Sustained effect of the intervention was demonstrated by a continued mean HbA1C decrease of 0.14 one year post-intervention. Improvements were also seen in diabetes knowledge ($p=0.01$). Systolic blood pressure for those with baseline >130 mmHg was reduced from 138.8 to 125.8, ($p < .01$) and diastolic blood pressure for those with baseline >80 mmHg was reduced from 90.8 to 79.8, ($p < 0.01$). The most sedentary patients showed an improvement of 2056 steps/day ($p=0.04$). Study 3 was a pilot study that aimed to evaluate the feasibility, acceptability, and preliminary effectiveness (compared with usual care) of a collaborative care model to treat patients with psychosis and poorly controlled diabetes. Stakeholder input was used to adapt a primary care-based collaborative care intervention for CMHC settings. Patients with type II diabetes and hemoglobin A1c (HbA1c) = 8% or high blood pressure ($n=35$) were randomized to collaborative care or usual care. After three months, intervention participants had a statistically significant mean decrease in HbA1c of 1.1% ($p=.049$) with no change in HbA1c in the usual care group. These reverse-integrated care behavioral research interventions were feasible, well-accepted, and effective in community mental health settings. Real world barriers to implementation include care coordination, cost effectiveness, and social factors associated with unhealthy lifestyle behaviors. Health

homes and Accountable Care Organizations may facilitate the availability of these interventions in behavioral health care settings, particularly if shown to decrease healthcare utilization costs.

Meaningful Quality Measures: Using PsychPRO to Place Measure Development in the Hands of Providers

Chair: Diana Clarke, Ph.D.

Presenters: Grayson Swayze Norquist, M.D., Jerry L. Halverson, M.D., Lauryn Wicks, Diana Clarke, Ph.D., Debra Gibson, M.Sc.

Discussant: Gregory W. Dalack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the importance of relevant performance measures in improving care quality; 2) Demonstrate knowledge of the technical expert panel and its role in the measure development process; 3) Provide an overview of consumer and family engagement as part of the measure development process; and 4) Describe the role of the registry, PsychPRO, in the measure development and testing process.

SUMMARY:

The development of meaningful quality measures for mental and substance use disorders is critically needed to ensure that patients are receiving high-quality, evidence-based care while minimizing burden for clinicians. The American Psychiatric Association (APA) was awarded \$5.38 million over 3 years to collaborate with the National Committee on Quality Assurance (NCQA) under a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS) to develop meaningful quality measures for behavioral health under the Medicare Access CHIP Reauthorization Act of 2015 (MACRA). These measures will address CMS's designated priority gap areas of mental health and substance use disorders, with a focus on measurement-based care, evidence-based care, and care experience. The initiative will engage consumers, technical experts, and a Learning Collaborative of 20 to 25 diverse behavioral health practice sites, involving 400 clinicians. A key component of the measure development process is the involvement of the Technical Expert Panel (TEP)

– in this case, a group of clinicians with expertise in mental and substance use disorders who are convened to review and evaluate scientific evidence supporting all aspects of measure development, including measure definitions, standardized assessment tools, and measure testing. Involvement of clinician stakeholders allows for CMS to better understand 1) performance gaps and disparities, 2) the reliability, validity, and feasibility of measure data collection, 3) usability, 4) harmonization with other quality measures and performance programs, and 5) clinician burden minimization. Clinicians who treat patients in the various outpatient settings for mental and substance use disorders and who join the Learning Collaborative will provide valuable advice to the TEP and Consumer and Family Panel (CFP) on the utility of these new measures. The session will highlight the measure development process and how multiple groups of stakeholders serve as advocates for the implementation of quality care in mental and substance use disorder treatment settings. During the session, each presentation will use audience polls to stimulate participant engagement and discussion.

Multilevel Integration of Pediatric Mental Health Services at an FQHC

Chair: Gertie D. Quitangon, M.D.

Presenters: Carolina Biernacki, M.D., Nicholas Figueroa

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the opportunities and challenges of mental health integration in an FQHC setting; 2) Understand the innovative approach of school-based mental health service delivery; and 3) Recognize the role of community based programs such as Teens PACT in preventing high risk behavior.

SUMMARY:

Mental health disorders in youth lead to significant morbidity, lower baseline functioning and loss of productivity well into adulthood. Poor mental health is strongly linked to developmental concerns, poor reproductive health, lower educational achievement, violence and substance use. Moreover, delayed treatment prolongs symptomatology and worsens

prognosis. Over twenty percent of children and adolescents experience a mental health disorder worldwide, and half of these disorders begin by age fourteen years old. Access to diagnosis and treatment, however, remains limited due to the scarcity of trained professionals as well as the stigma associated with mental illness. Integrating mental health services into more widely accessible settings such as primary care clinics and schools therefore presents a unique opportunity to widen access to care, lessen stigma, and ultimately diminish the burden of illness on both individual and societal levels. Federally Qualified Health Centers (FQHC) are strategically positioned to make mental health services more widely available while also destigmatizing the need for mental health treatment. During this session, we will discuss our experience of implementing such adolescent mental health integration at Community Healthcare Network (CHN), a New York City-based FQHC. We will guide participants through the required elements and optimal circumstances for integration while examining potential challenges of such a process. FQHCs also have unique collaborative opportunities to expand mental health service integration to alternate settings such as schools and after school programs. CHN has been providing school-based primary care at two distinct locations serving a total of six schools, which has allowed for the introduction of mental health services onsite. Our session will discuss mental health integration in this new setting by outlining the services and workflow at Phoenix and Seward, our school-based clinics. Finally, participants will discover the value of FQHC involvement in non-healthcare settings such as afterschool programs. We will examine CHN's partnership with Positive Actions and Choices for Teens (Teens PACT), a program aimed at preventing teen pregnancy and sexual transmitted diseases through engagement in teen leadership.

Patient Engagement and Facilitating Change in Patient Centered Care: Integrating Motivational Interviewing and Shared Decision Making

Chair: Michael A. Flaum, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Compare and contrast MI and SDM in patient centered care; 2) Provide and discuss examples of the clinical scenarios appropriate for SDM vs. other MI consistent approaches; and 3) Identify elements of MI and SDM in case vignettes of recovering patients with severe mental illness.

SUMMARY:

Motivational Interviewing (MI) and Shared Decision Making (SDM) are two evidence-based approaches to patient-centered care. While they share several elements in terms of their underlying spirit, including profound respect for individual autonomy and the value of collaboration, there are important differences in their techniques, goals and in the clinical situations for which they are appropriate. MI was developed as a way of helping people who are engaging in risky and otherwise unhealthy behaviors make changes towards a specific behavioral goal. SDM is typically used to help patients make optimally informed choices among reasonable options. For care to be genuinely patient centered, it is important for the clinician to be at least aware of, if not transparent about, which of these approaches they are drawing upon at any given time and in which clinical circumstances. Some clinical situations clearly lend themselves to one rather than the other, but many times, there are grey areas. For example, working with a patient to choose among antipsychotic medications is one situation for which SDM would seem to be indicated. Working with a patient who feels strongly against using any medication, and who repeatedly winds up having severe exacerbations each time they do not adhere with a prescribed medication plan is one that likely calls for MI. But what about working with a patient just coming out of an acute first episode psychosis, which may have been substance-induced and resolved with abstinence along with a brief course of antipsychotics? The clinician's instinct may be that this is indeed schizophrenia, and that the person should continue medication for at least several months if not longer, but the person feels back to normal and seems to prefer a wait and see approach without meds. One could imagine a conversation that looked for all intent and purposes like SDM, but which would score highly on any measure of MI fidelity. Is it MI or is it SDM? And what difference

does it make? Is it important to know? In this session we will explore the answer to these questions. We will suggest that the ultimate goal is to be able to appropriately and fluidly apply these two approaches, and that to do so requires an understanding of each and an ability to accurately distinguish one from the other. Participants will practice with case vignettes in small groups to help recognize and discuss elements of each approach and their rationale and appropriateness for the clinical situation.

The Intersection of Serious Mental Illness and Opioid Use Disorder: Treatment Innovation Within the Community Mental Health Center Setting

Chair: Jeffrey C. Eisen, M.D., M.B.A.

Presenters: Margaret M. Chaplin, M.D., Narsimha R. Pinninti, M.D., Justine J. Larson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To describe the prevalence of co-occurring Serious Mental Illness (SMI) and Opioid Use Disorder (OUD) in the United States; 2) To discuss the complexity of interaction of other characteristics, including pain and trauma, that co-occur with SMI and OUD; 3) To elucidate clinical, cultural, and operational approaches to successfully implementing OUD treatment within the CMHC and community psychiatric settings.; and 4) To consider further opportunities to develop OUD specific programs, specifically MAT, within the CMHC and community psychiatric settings.

SUMMARY:

Despite representing only 16 percent of the adult population, adults with mental health disorders receive more than half of the 115 million opioid prescriptions distributed each year in the United States (SAMHSA, August 2018). In addition, according to the 2015 National Survey on Drug Use and Health (NSDUH), one in eight individuals (13 percent) who misused opioids during the study period also had Serious Mental Illness (SMI). These data suggest an epidemic of opioid use, and related overdose, among individuals already served within a Community Mental Health Center (CMHC) setting. Furthermore, there is a growing recognition that Opioid Use Disorder (OUD) is also frequently

complicated by additional substance use disorders, trauma, physical health issues such as viral hepatitis, and devastating social service needs such as disability, unemployment and housing insecurity. Though many challenges exist in the development and implementation of programs targeted to opioid use disorder (OUD) in this environment, CMHCs are by nature an ideal setting as they already incorporate the concept of a biopsychosocial approach to recovery and provide a much needed access point for treatment. This presentation will feature leaders from across the county who have developed sustainable OUD programs, specifically Medication Assisted Treatment (MAT), within CMHCs. The presenters will show how the treatment of OUD in a CMHC setting addresses all the patients' needs in a comprehensive fashion in order to build sustained abstinence and meaningful recovery, as well as elucidate the clinical, financial, operational, and cultural learnings that occurred through the efforts.

The Intersection of the Criminal Justice System and People With Mental Disabilities: Are We All Speaking in Different Tongues?

Chair: Elizabeth Kelley, J.D.

Presenters: Stephanie Tabashneck, J.D., Psy.D., Jennifer Johnson, Eric Drogin, Henry Dlugacz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that different stakeholders have different goals, ie: confidentiality v. candor, rehabilitation v. deterrence, treatment v. punishment; 2) Recognize that different stakeholders have different vocabulary, ie: competency, sanity, justice; 3) Recognize that different professions have different truth-finding mechanisms, ie: the adversarial system; and 4) Identify areas of common understanding and further collaboration, ie: ABA Mental Health Standards.

SUMMARY:

Because of the large number of people with mental disabilities in the criminal justice system, all stakeholders -- criminal defense lawyers, prosecutors, judges, law enforcement, jail/prison officials -- have embarked upon all sorts of innovative programs such as CIT training and

problem-solving courts. These developments have drawn from a variety of disciplines such as psychiatry, psychology, and social work, to name a few. But will progress necessarily be limited because the criminal justice system is based on an adversarial model? Do various ethical standards and practice guidelines conflict? Do we lack a common vocabulary or even common goals? The participants in this panel all have law degrees, but have additional training and experience in fields such as academia, civil rights, psychiatry, psychology, and social work.

Treatment Plans—Necessary Documents or Undue Administrative Burden? The Implications for Psychiatrists and AACP Position

Chair: Dianna Dragatsi, M.D.

Presenters: Kenneth Minkoff, M.D., Isabel K. Norian, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the historical significance of the; 2) Discuss potential alternatives to the traditional treatment plan document; 3) Be informed about the relevance of parity in the discussion of the treatment planning process; and 4) Be empowered to discuss treatment planning and clinically relevant documentation with their local stakeholders.

SUMMARY:

The American Association of Community Psychiatrists (AACP) has published a position statement regarding treatment plans. We regard treatment plans, a documentation requirement, in this position statement, as distinct from the process of treatment planning. The AACP is concerned that treatment plan documentation in its current state, creates unnecessary administrative burden for physicians, without evidence of benefit for patients, reducing direct patient contact time, thereby negatively impacting quality of care. In this position, we echo the statements made by the American College of Physicians in their position paper entitled "Putting Patients First by Reducing Administrative Tasks in Health Care". We recommend a review of the treatment plan documentation requirement across the nation, engaging consumers, providers, and

regulatory agencies in all states, as well as national reimbursement and regulatory agencies, in order to promote the process of quality driven care and documentation. In this session, we hope to engage participants in a discussion about the treatment planning process, and provide them with the information necessary to engage their local stakeholders in a review of the "treatment plan" document as it exists, providing them with clinically relevant alternatives. They will be able to discuss how current documentation requirements of treatment plans and its implications for reimbursement do not meet parity rules and regulations, in addition to reducing direct patient care contact.

Friday, October 04, 2019

All Hands on Deck: Implementing Cognitive Behavior Therapy for Psychosis (CBTp) in Routine Care Settings in the U.S.

Chair: Sarah L. Kopelovich, Ph.D.

Presenter: Harry Sivec, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) articulate the rationale and primary goals associated with Cognitive Behavioral Therapy for psychosis; 2) understand the theoretical principles of Cognitive Behavioral Therapy for psychosis; 3) use at least one CBT-informed strategy to assess and address concerns related to taking medications; and 4) have access to at least 3 resources to pursue additional education or training in Cognitive Behavioral Therapy for psychosis.

SUMMARY:

Cognitive Behavioral Therapy for psychosis (CBTp) is an evidence-based psychotherapeutic intervention for psychotic symptoms that has been studied in more than 50 randomized clinical trials and more than 20 meta-analyses and systematic reviews. The intervention is listed as a recommended adjunctive treatment in United States treatment guidelines for schizophrenia spectrum disorders. Nevertheless, CBTp has failed to become the standard of care for individuals with psychosis in the United States. Accordingly, efforts to more flexibly implement and administer CBTp are being explored empirically,

including engaging a range of disciplines in the provision of CBTp protocols and CBTp-informed strategies. This workshop will provide an orientation to the empirical support of CBTp to address various clinical outcomes, and identify proposed solutions to the challenges associated with adoption of CBTp in routine care settings in the United States. The session will provide didactics and demonstration of CBTp principles and strategies that can enhance the therapeutic alliance, therapeutic engagement, and healthcare quality when working with individuals who experience psychosis. Experiential exercises and examples will be used to demonstrate strategies informed by CBTp that represent foundational skills for addressing psychotic symptoms.

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.

Can Addicts Stop Using? A Review of the Roles of Morality and Neuroscience in Shaping the Free Will—Determinism Duality in Substance Use Disorders

Chair: Elie G. Aoun, M.D.

Presenter: Hector Colon-Rivera, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate how the free-will/deterministic duality reflects on the societal perception of SUD; 2) Understand the scientific evidence supporting the volitional control of behaviors in SUD; 3) Understand the scientific evidence supporting the impaired behavioral control of behaviors in SUD; 4) Discuss whether the course of addictive disorders is pre-determined by neurobiological factors or open to spontaneous course alteration; and 5) Examine whether the concepts of SUD as a brain disease or as volitional phenomenon are incompatible.

SUMMARY:

For a person with substance use disorder (SUD), using substances or engaging in substance related behaviors are inconsistent with the person's best interests and are often seen as a reflection of their moral values. In thinking about the stigma surrounding SUD, one may ponder about the reasons for the commonly held moralized view of addiction. While the answer to this question is complex and multifactorial, one important aspect relates to the nature of behaviors associated with substance use and their apparent absurdity, as one hallmark of SUD is continued compulsive substance use despite any negative consequences affecting them, those they love and society at large. This may easily be interpreted as a reflection of the person's wickedness. However, given our understanding of phenomenological processes in SUD, such assertions are naïve and incorrect. Indeed, it is widely accepted that the ability of persons with SUD to comport themselves in a socially acceptable manner is somewhat impaired, and as such, they may find it more difficult to abstain from engaging in certain condemned behaviors. As such, beyond the superficial aspect of SUD marked by using substances, a deeper conceptualization of such disorders involve a disorder affecting a person's

decision making abilities. It appears that in such a model, as individuals develop addictive disorders and the severity of their disorders increase, as their valuation of the addictive substance increases, their valuation of non-addictive processes decreases. As such, for persons with SUD, as the positive and the negative reinforcement associated with drug or alcohol use increases, they become less likely to find comfort or relief when engaging in activities that they used to value positively. Furthermore, in some situations, persons initiate the use of drugs or alcohol voluntarily for recreational purposes, yet go on to develop a SUD. Whether that means that the person is voluntarily taking the risk of having a SUD and whether that should matter remains up for debate. The courts have ruled that while SUD is not a status crime, behaviors related to using substances are not driven by an "irresistible compulsion" that the person would be "utterly unable to control" (Powell v. Texas, 1968). As such, having a SUD does not obliterate wholly a person volitional control over their behaviors. Such rulings highlight the free will/deterministic duality for SUD in constitutional jurisprudence. In this presentation, we consider how such duality reflect on the societal perception of SUD as well as the scientific evidence supporting either argument. One may challenge whether refraining from We also examine whether the course of addictive disorders is pre-determined by neurobiological factors modulated by past experiences or open to spontaneous course alteration based on drives and desires. We further examine whether the concepts of SUD as a brain disease or as volitional phenomenon are incompatible.

Certified Peer Support Specialists: Leveraging an Underutilized Resource to Enhance the Continuum of Care for People With Serious Mental Illness

Chair: Patrick Hendry

Presenters: Benjamin G. Druss, M.D., Amy Cohen, Teri S. Brister, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the credentialing and continuing education expectations of certified peer support specialists.; 2) Participants will understand the role of the certified peer support

specialists as part of an integrated treatment team.; 3) Participants will identify the research base for using peer support specialists among people with SMI.; 4) Participants will recognize the benefits and challenges that can occur when certified peer support specialists are part of the treatment team and how to address challenges.; and 5) Participants will recognize the unique benefits offered by certified peer specialists to patient care, and the value add of actively engaging them in their practice..

SUMMARY:

This interactive session will explore the opportunities, benefits, and challenges of integrating peer-specialists in diverse clinical settings. Through interactions with audience members, this session will explore how peer support specialists play an important and unique role in service delivery and recovery support for people living with mental illness. Peer support specialists are a rapidly growing workforce in behavioral health. In a 2014 report there were approximately 14,000 certified peer specialists in the country; by 2016 that number had grown to approximately 24,000; by 2018, peer specialists numbered over 30,000, and that number doesn't include the over 6,000 peer support workers in states without certification. Peers specialists can now be found in numerous settings including: 1) inpatient services, 2) emergency departments, 3) community mental health outpatient services, 4) mobile crisis teams, 5) peer-run respite facilities, 6) primary care practices, 7) whole health care teams, and more. (Gagne, 2018) Agencies and practices are now evaluating peer support's usefulness in complementing clinical services, potential benefits to people receiving services, and benefits to their families. As peer support plays an increasing role in clinical services we are faced with several important questions: How to identify/hire excellent peer specialists?; How do peers work alongside clinicians and in clinical environments while remaining a strictly non-clinical service that is focused on the essential ingredient of being a peer?; How do we provide appropriate support and supervision?; and How do we establish peer specialists as respected members of treatment teams? The introduction of peer support into agencies and practices creates change, for both the clinical team and the patient

population, with an increased and beneficial focus on recovery. When traditional treatment teams work alongside peer specialists, they are reminded of the path to recovery; hope is stimulated; and the perspective of the client is revived. Peer support staff function as "change agents" within the culture of organizations. There remain many questions about the expanded use of peer support in mental health services and there are challenges to be met in its' implementation.

Creating a Statewide Continuum of Substance Use Treatment Services: The Community Care Model

*Chairs: Matthew O. Hurford, M.D., David Loveland
Presenter: Rebekah Sedlock, L.C.S.W.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Engage addiction treatment providers to improve quality of care; 2) Use data for ongoing process improvements as well as to move practices away from experiential guidance and toward measurement-based care; 3) Engage patients in a continuum of care through a series of small, meaningful modifications to the assessment and triage process; and 4) Use learning principles to develop value-based payment strategies that support desired treatment outcomes.

SUMMARY:

Participants will be involved in designing a continuum of addiction treatment services, based on a case study from Pennsylvania (PA). Participants will be guided through a series of questions to consider in transforming systems built on reacting to momentary needs into a proactive continuum for people with a substance use disorder (SUD), with a focus on those with an opioid use disorder (OUD). Each interactive step will be supported with strategies used by a non-profit managed care company (MCO) to organize 222 unique organizations with nearly 350 locations or levels of care, serving approximately one million Medicaid members. Participants will learn how the MCO is using data to both inspire and empower organizations to improve retention and follow-up rates for individuals with a SUD. The audience will consider the following three stages of the continuum in redesigning care: 1. Creating easy access to

treatment through proactive models of care, 2. Increasing retention through effective triage and integrated care, and 3. Focusing on the continuum as the primary objective, with an emphasis on financing a long-term model of care. Participants will be guided through a functional view of treatment providers, by learning how the present model of addiction treatment was formed through the fee-for-service system and for people with an alcohol use disorder (AUD). The audience will learn how the MCO is collaborating with agencies to develop an integrated continuum for individuals with an OUD, who now account for 60% of all residential beds in PA. Notably interventions used and discussed in the presentation includes: ? providing ongoing education on effective practices, ? using data feedback loops to empower agencies, ? acquiring federal grants to test new treatment models, ? creating standards of care across all providers, ? developing clinical pathways for people with an OUD, ? integrating physical health care within behavioral health services, ? merging medication assisted treatment (MAT) with abstinence-based services in all treatment providers, and ? developing value-based payment structures to increase retention, follow-up care, and the use of evidence-based treatments, including MAT. Outcome data will be used within each step, highlighting the benefits of viewing treatment providers as the solution to the opioid epidemic in PA. Notably outcomes reviewed include a two-fold expansion of MAT over three years, retention and costs data for individuals with an OUD who access MAT, and retention and follow up data for individuals receiving residential treatment.

Disseminating Community Partners in Care (CPIC) to Improve Outcomes for Depressed Adults

Chair: Bowen Chung, M.D.

Presenters: Kenneth Brooks Wells, M.D., M.P.H., Eliot Goldman, Ph.D., Kishor Malavade, M.D., Benjamin Springgate, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the CPIC study outcomes; 2) Describe CPIC's coalition model to address depression across healthcare and

community organizations; and 3) Understand CPIC implementation in New York City and Louisiana.

SUMMARY:

Depression is a leading cause of adult disability in the U.S. and affects 15 to 20 percent of people at some point in their lives. Evidence-based depression treatments, such as antidepressants or therapy, often are not available in these neighborhoods because of poor access to services and obstacles such as stigma or cost. Our session summarizes how the Community Partners in Care study demonstrated that improving care for depression in low-income communities — places where such help is frequently hard to find — provides greater benefits to those in need when community groups such as CBOs, faith leaders and even business owners (e.g. hairdressers, barber shops) help lead the planning process. When compared to efforts that provided only technical support to improve depression care, a community coalition planning effort co-led by community members from diverse services programs further improved clients' mental health, increased physical activity, lowered their risk of becoming homeless and decreased hospitalizations for behavioral problems by 50% at 6-months with continued improvements in mental health related quality of life and reduced behavioral health hospitalizations at up to 3 years. CPIC's coalition intervention supported healthcare and community-based agencies as network partners in integrated behavioral health, including adaptation of depression quality improvement (QI) resources to local communities and task-shifting to community-based agencies. For example, primary care settings may provide medication management and information on locally-valued alternative practices, while substance abuse settings provide case management for shared clients. Both interventions used the same evidence-based depression QI toolkit. Based on the CPIC study findings, policymakers, community leaders, and health systems have decided to implement CPIC in other cities. During our session, we will share with participants examples of CPIC dissemination and implementation efforts in a) New York City with the Department of Health and Mental Hygiene (DOHMH), with particular emphasis on Maimonides Health System's partnership with a local Arab American community in Brooklyn within the context

of managed Medicaid; b) in Louisiana. The New York City DOHMH will share their experience with health system engagement and adaptation to local community conditions. Maimonides will share their experiences in CPIC implementation as an engagement strategy with Arab Americans in a managed Medicaid model. And New Orleans will share how CPIC is being implemented and adapted as part of a funded randomized trial to address depression and social determinants of health.

Help APA Build the Meeting of the Future: An Interactive Town Hall Looking at IPS: The Mental Health Services Conference in 2021 and Beyond

Chairs: Glenn Laudenslager, Jacqueline M. Feldman, M.D.

Presenter: Anita Everett, M.D.

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.

Inpatient Treatment For People with Autism and Intellectual Disability: Developing Services and an Evidence Base

Presenter: Matthew S. Siegel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify behavioral and psychiatric disorders seen in Intellectual disability and autism spectrum disorder; 2) Explain the core elements of a multi-disciplinary treatment approach to challenging behaviors in individuals with intellectual disability or autism spectrum disorder; and 3) Illustrate best practice recommendations for inpatient multi-disciplinary care of individuals with intellectual disability and autism spectrum disorder.

SUMMARY: Objective: The etiology of significant behavioral challenges in youth with Autism Spectrum Disorder (ASD) or Intellectual Disability (ID) is frequently multi-factorial, potentially including psychiatric, medical, occupational, communicative, family and environmentally reinforced components, among others. Psychiatrists are uniquely positioned to oversee a multi-disciplinary treatment plan for this population (AACAP, 2014), but may not have experience in building programs that draw on other disciplines. **Method:** The presenter will build upon recent research evidence (Pedersen et al, 2017) and best practice publications (McGuire, 2015) to illustrate the evidence for approaches to complex behavior in people with developmental disabilities. The process of developing a multi-level system of care for this population will be discussed, and risks and benefits identified. **Results:** From inpatient to outpatient levels of care, a multi-disciplinary culture of care can be utilized to address refractory behavioral challenges in youth with developmental disabilities. Access to specialists in communication, occupational therapy, family systems, case management, applied behavioral analysis and other disciplines can be aligned to produce improved outcomes. **Conclusions:** Individuals with ASD and ID can develop serious behavioral and psychiatric challenges that are refractory to approaches from a single discipline. Developing a continuum of care for this population, including inpatient, day treatment, outpatient, phone consultation and other services will be discussed and avenues for success identified.

Integrated Care's Final Frontier: Inserting Primary Care Into Assertive Community Treatment (ACT) Services

Chair: Edward Tabasky, M.D.

Presenters: Jeanie T. Tse, M.D., Gertie D. Quitangon, M.D., Jason Cheng, M.D., Erik Rudolph Vanderlip, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the unique challenges of patients receiving ACT care and its effects on physical health; 2) Recognize the importance of addressing these unmet needs for individual patients and the health system as a whole; 3) Understand the role of psychiatrists in addressing these unmet needs and bridging the gap between physical and mental health needs; 4) Identify current state of integration of primary care into ACT services and the roadblocks keeping this from disseminating; and 5) Examine current efforts to insert primary care services into ICL's ACT teams and their results.

SUMMARY:

People receiving public mental health services die approximately 25 years younger than people in the general population (1). For people with schizophrenia, about 60% of premature deaths are due to treatable and preventable medical conditions such as heart disease, stroke, and diabetes (1). The majority of community mental health centers do screen for obesity and hypertension and over 1/3 screen for hyperlipidemia and diabetes (2). However, people with mental illness have poor access to treatment and poor quality of preventive care (3). These poor outcomes are associated with significant financial cost. For patients served by Assertive Community Treatment (ACT) teams, the outcomes are likely more dire. Individuals are eligible for ACT services if they have been hospitalized multiple times in the past year (the required number varies by state), usually due to treatment non-adherence caused by lack of insight into illness, poor executive function, substance abuse, homelessness, and social isolation and disenfranchisement. Practitioners on these teams have long noted that the missing element on these teams is adequate primary care, as many individuals will not access traditional health care services, just as they have not accessed traditional psychiatric services. Psychiatrists are experts in behavior change, which is fundamental to achieving better health outcomes; healthy eating, exercise, smoking

cessation and medication adherence are all behaviors. Using motivational enhancement techniques and trauma-informed approaches, psychiatrists can have a unique role in helping people manage cardiometabolic and other physical health conditions. There have been several studies examining models for inserting primary care services into the ACT framework using colocated or embedded primary care providers (4), as well as consultation of psychiatrists with a primary care provider. It appears that communication between the team and the primary care service was a greater determinant of care than location of provider.(5,6) Institute for Community Living, Inc. (ICL) has partnered with Community Healthcare Network (CHN) in order to provide reverse co-located care on ICL's ACT services in order to assess the feasibility and acceptability of this method of primary care service provision and to determine whether the proposed intervention improves health outcomes including blood pressure, cholesterol, diabetes and smoking risk indicators, and whether it reduces avoidable, high-cost emergency and inpatient service utilization. This has been accomplished via a two prong approach, through the collaboration with CHN, by bringing Family Medicine Nurse Practitioner Fellows directly into the ACT teams as well as opening a Federally Qualified Health Center in the same space and creating streamlined referral and data sharing processes.

Interview-Based Assessment of Cognitive Deficits in People With Serious Mental Illness

Presenters: Joseph Ventura, Ph.D., Alexander S Young, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize cognitive deficits that are frequently observed in people with psychotic disorders; 2) Recognize cognitive deficits that are frequently observed in people with psychotic disorders; and 3) Screen for cognitive deficits in the routine care of patients.

SUMMARY:

The cognitive deficits that can accompany serious mental illness are highly prevalent and have serious functional consequences. This knowledge has

expanded the target of therapeutic interventions beyond symptom management alone. Enhancing the focus of treatment for these illnesses requires the implementation of cognitive assessment in routine clinical practice. However, assessments using standardized neuropsychological batteries are difficult to implement since the administration of a test battery requires more time and assessor training than is typically available in clinical settings. In routine clinical care, obtaining patient oriented information on cognitive functioning can supplement any objectively collected data. Interview-based measures of cognition include the Cognitive Assessment Interview (CAI). This method for assessing cognitive functioning in people with serious mental illness has been shown to be reliable, valid, and sensitive to treatment effects. Recent research has also shown strong relationships between the CAI, objective cognitive assessment and multiple domains of daily functioning such as independent living, social interactions, family relationships, and school or work functioning. These assessments are more closely related to a patient's functioning than traditional approaches of objective neurocognitive assessment. This session will review the role of cognition in serious mental illness and the evidence supporting interview-based assessment. The CAI will be introduced and participants will be provided with instruction on the use of the CAI to assess cognitive functioning in their patients.

**Mobile Mental Health Meets Clinical Psychiatry:
New Tools for New Models of Care**

Chair: John Torous, M.D.

Presenters: Hannah Wisniewski, B.S., Liza Hoffman, L.I.C.S.W., M.S.W., Ryan Hays, Keris Jän Myrick, M.B.A., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least three areas where smartphone applications and wearable sensors can support the delivery of mental healthcare and psychiatric services.; 2) Understand patient sentiment and interest in using smartphone applications and wearable sensors to monitor their own mental health.; 3) Understand the difference between passive and active data, and identify how smartphones and sensors can collect data on self-

reported symptoms, behaviors, and physiological measurements.; 4) Recognize the potential of new research models using smartphones and wearable sensors and how such can inform clinical practice and patient care today; and 5) Understand how to evaluate the role of mobile mental health technology in community clinical practice through accurately identifying the barriers, risk, and benefits to patients..

SUMMARY:

As interest in digital technologies like smartphone and sensors for psychiatric care continues to expand, it is important that psychiatrists remain educated and informed about the potential and pitfalls of these new technologies. In this seminar we will cover four core areas of direct interest to those providing psychiatric services: patient engagement / adherence, new clinical data streams, clinical experience using smartphones, and picking the right smartphone apps.

People With Mental Illness in the Criminal Justice

System: Answering a Cry for Help

Chair: Kenneth Minkoff, M.D.

*Presenters: Stephanie Le Melle, M.D., M.S.,
Jacqueline M. Feldman, M.D.*

Discussant: Fred Charles Osher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the experiences of individuals and families with mental illness and substance use disorders in the criminal justice system; 2) To be familiar with the use of the sequential intercept model to design interventions to prevent and reduce incarceration; 3) To learn and practice specific strategies at each intercept for how to improve outcomes as an individual practitioner; 4) To learn specific strategies for how to make a difference in your own organization, program, or system; and 5) To understand how to create a system impact through participation in the national Stepping Up Initiative.

SUMMARY:

Justice involvement of people with mental illness, often with co-occurring substance use disorders, has reached critical levels. Hundreds of thousands of

people with serious mental illness are incarcerated, and many more are under community correctional supervision. An APA publication from the group for the advancement of psychiatry (GAP) committee on psychiatry and the community serves as the foundation for this participatory workshop. The focus of the workshop is not just to describe the problem, but, using the results of the GAP publication, engage participants in small group discussions with workshop leaders, using case examples from the GAP publication, to identify how participants can take action, in their own practices, programs, and local systems, within available resources. To answer the cry for help. The foundation of the GAP report was soliciting letters from Dear Abby's column describing stories of individuals and families with BH conditions who had been incarcerated. The committee received over 3000 letters. These letters not only engage the listener in the experiences of "real people", they are used by the committee as "case examples" for illustrating innovative practice and program approaches for improving services to prevent or reduce incarceration. In line with the report, the workshop will organize the presentation and small group discussions according to the sequential intercept model, developed by Dr. Mark Munetz, one of the committee members. At each intercept point, there are illustrations for how to respond to the scenarios in the letters, with recommendations for action steps that lead to changes in clinical practice, program policy, and local system collaboration, that can be undertaken by psychiatrists, program leaders, and other practitioners, working at any level. After introducing the letters and describing the sequential intercept model, each presenter will focus on a particular intercept, using specific examples. The intercepts include: provision of proactive and welcoming crisis response to prevent arrest; partnering with law enforcement and court personnel after arrest; collaborating with judges around sentencing and therapeutic justice: partnership between community systems and jail-based services; and partnership with community corrections to provide integrated interventions to address co-occurring disorders and criminogenic risk. Each of these areas will provide structure for breakout discussion groups in which participants will have an opportunity to think with workshop leaders about

what they might be able to change in their own settings. Finally, our discussant will summarize the small group work and engage participants in thinking about opportunities to influence systems change on the state and national level through describing the national "stepping up" initiative.

Population Health Impact and Sustainability of Behavioral Health Integration in Primary Care: The Role of Psychiatry and Technology

Chairs: Henry Chung, M.D., Varsha Narasimhan
Presenters: Michelle Blackmore, Sarah Ricketts, M.D., Kelly Carleton

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the behavioral and medical population health impact of the integrated collaborative care model (CoCM) for low income, ethnically diverse, and medically complex patients.; 2) Describe the role of psychiatrists as essential providers, facilitators, and innovators critical to the success of integrated care and discuss suggestions for a fellowship training model.; 3) Review opportunities to augment the CoCM with technology.; and 4) Explain how to apply lessons learned and address opportunities to enhance patient engagement and outcomes in the real-world implementation of the CoCM..

SUMMARY:

The collaborative care model (CoCM) is effective in treating patients with common behavioral health disorders in primary care settings, improving clinical outcomes and reducing costs. Key components of the CoCM include measurement-informed care facilitated by a patient registry, systematic care management, and psychiatric supervision and consultation. Despite the promise of this model, widespread implementation in real-world community settings with varying resources and diverse patient populations is limited. Montefiore Health System, a leader among academic medical centers embracing value-based models and population health, examined the impact of the CoCM in a 4-year implementation. With an eye towards sustainability, psychiatry fellowship training was incorporated into the model, as well as mobile technology to augment the CoCM. Our findings

illustrate the benefits of the CoCM in primary care for a low-income, ethnic minority population (N = 5,603) with depression, anxiety and comorbid medical conditions (e.g., diabetes, cardiovascular disease). Clinical improvement was shown in 49% and 50% of the population on the PHQ-9 for depression and GAD-7 for anxiety disorders, respectively. Patients also had 12-month improvement across medical conditions shown by a mean change from baseline of 0.82 in HbA1c levels, 21.78 in LDL levels, and 18.90 in systolic blood pressure. Both the behavioral and medical outcomes achieved were comparable to or exceeded reported outcomes in key research and observational studies (Katon, Lin, Von Korff, et al, 2010; Rossom RC, Solberg LI, Parker ED, et al, 2016). However, a closer look at the CoCM impact on addressing the population health needs of our patients revealed opportunities to better adapt the model, engage patients, and maximize resources, essential for the model's larger scale adoption. For instance, out of the 13% of patients (N = 11,886) who scored in the clinically significant range on the PHQ-9 or GAD-7 following universal screening, only 47% (N = 5,603) agreed to treatment. This session will describe lessons learned and the population health impact of Montefiore's real-world implementation of the CoCM, with a multi-modal approach to sustain quality care. Speakers will review the CoCM's clinical impact on behavioral and medical health comorbidities, with a focus on the role of psychiatrists as leaders and innovators in integrated care. Suggestions for a fellowship training model will be described, with both the benefits and challenges of learning the CoCM approach for the first time, given exposure to the model in residency training is so limited. Attendees will gain unique insight on how psychiatrists can assist in aligning with value-based payment workflows and quality improvement strategies for the attainment of better physical and behavioral outcomes. Data on using technology in a feasible and patient-centric manner to augment the CoCM will also be discussed.

Preventing the Unthinkable: Building Partnerships to Disrupt Targeted Violence and Mass Shootings

Chair: John S. Rozel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how multidisciplinary threat management programs can help clinical teams recognize people at risk of serious violence; 2) Describe how threat management and protective intelligence approaches to clinical scenarios may yield new considerations in mitigating clinical violence risk; 3) Identify and engage potential collaborators in violence risk management outside of their current operational silo; 4) Describe the limited but significant overlap between violence and mental illness including mass violence; and 5) Explain how threat management differs from traditional mental health assessment and treatment.

SUMMARY:

During an active shooting event, Run/Hide/Fight saves lives. Stop the bleed saves lives. Tactical medicine saves lives. They are not enough to stop the increasing trend of mass and targeted violence and shootings in the United States. Mass shootings have become a distinctly American phenomenon – one not seen to this degree in any other economically developed country. While homicide and violent crime have fallen over the past decades, mass shootings are trending upward in frequency and severity. Popular debate drives stigmatizing and inaccurate perceptions of assailants as mentally ill and also masks practical, reasonable strategies to identify and intervene before these events occur. The phenomenon of active shooters are a complex problem, in both the colloquial and the scientific meaning of the word. There are no easy, quick, or complete fixes for this evolving threat to public safety, but there are tools which can make a significant difference. Offenders in active shootings are not clearly any more frequently mentally ill than the general population, however, as a complex behavior, psychiatrists are well suited to understanding and potentially crafting meaningful interventions to prevent such attacks. This talk moves beyond traditional psychiatric evaluation and management into threat management, integrating concepts and tools developed by law enforcement, security, and intelligence and brought to bear on the shared goal of stopping targeted violence before it occurs. Importantly, this talk will discuss how multidisciplinary threat management programs are created and how attendees can create or support

these programs in their own institutions and communities. Examples will be drawn from actual clinical cases and will demonstrate the role and need of multidisciplinary collaboration to prevent intentional violence. Practical models will be identified that aid professionals in evaluating targeted violence and the general spectrum of clinical violence risk we encounter every day.

SAMHSA Priorities Fireside Talk

Chair: Saul Levin, M.D., M.P.A.

Presenter: Elinore McCance-Katz, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate new research and treatment strategies into clinical practice; 2) Identify and improve mental health disparities in the community; 3) Recognize how to bring new innovations into a variety of treatments to improve patient care; and 4) Advance and update skills in community psychiatry treatment.

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 American 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. Join APA's CEO and Medical Director, Dr. Saul Levin, M.D., M.P.A., as he interviews SAMHSA's Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance-Katz, M.D., Ph.D., to discuss SAMHSA's priorities and discuss what's on the horizon for the agency. This session will also provide the opportunity for the Assistant Secretary to listen to the needs of psychiatrists and the patients you serve. Psychiatry has a voice in our federal government, and this session is intended to be an avenue through which the voice of psychiatry is heard.

Strengthening the Mental Health Workforce for Improved Care Delivery and Outcomes for Individuals With Serious Mental Illness

Chair: Benjamin G. Druss, M.D.

Presenters: Helle Thorning, Ph.D., Amy N. Cohen, Ph.D., Patrick Hendry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Review the current makeup and distribution of the mental health workforce serving individuals with serious mental illnesses (SMI) in the United States.; 2) Learn about effective care models that use multi-disciplinary teams to improve access and care quality for populations with SMI.; and 3) Identify opportunities to retain and support an effective mental health workforce that delivers evidence-based care for individuals with SMI..

SUMMARY:

There is an urgent shortage of mental health providers caring for individuals with serious mental illness (SMI) in the United States. Factors contributing to this shortage include gaps in the training pipeline; geographic maldistribution of providers; inefficiencies in team functioning; and low rates of acceptance of Medicaid and other forms of insurance. These issues can lead to challenges in recruiting and retaining public sector clinicians, and in those providers' ability to deliver high quality care to their patients with SMI. This symposium will address current issues and future opportunities for building and leveraging the mental health workforce for individuals with SMI. The symposium begins with updated statistics about the numbers, geographic distribution, acceptance of Medicaid and other insurance by specialty mental health providers. There will be information about successful models that leverage the differential training and skills of a multi-disciplinary team leading to reduced inefficiencies and better patient outcomes. Perspectives from different disciplines working with those with SMI will discuss care delivery priorities, training, retention, and opportunities to incentive their work in usual care settings. The multidisciplinary panel will include representation from psychiatry; social work; psychology; and certified peer specialists.

Supporting ECPs and RFMs in Their Careers and Beyond: Conversation With the APA CEO and Medical Director

Chair: Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe challenges faced by ECPs; 2) Identify and improve mental health disparities in the community; and 3) Recognize how to bring new innovations into a variety of treatments to improve patient care.

SUMMARY:

This session is open to APA members who are active Early Career Psychiatrists. In a small group discussion with APA CEO and Medical Director Saul Levin, ECP's will have an opportunity to discuss challenges faced by early career psychiatrists in their clinical setting and to brainstorm ways in which the APA might be able to assist. Topics for discussion include the future of psychiatric care, challenges related to career advancement, workforce development, and leadership development.

Supporting Medical Directors in Behavioral Health Clinics

Chair: Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe challenges faced by directors of behavioral health clinics; 2) Identify and improve mental health disparities in the community; and 3) Recognize how to bring new innovations into a variety of treatments to improve patient care.

SUMMARY:

This session is open to APA members who are active medical directors in behavioral health clinics. In a small group discussion with APA CEO and Medical Director Saul Levin, medical directors will have an opportunity to discuss challenges faced in the community setting and to brainstorm ways in which the APA might be able to assist. Topics for discussion include administrative and payment challenges faced in the FQHCs, challenges related to staff recruitment, contracting, workforce development, and leadership development.

The Clinician's Guide to Cognitive Rehabilitation for Neuropsychiatric Conditions

Chair: Jimmy Choi, Psy.D.

Presenters: Alice Medalia, Ph.D., Morris D. Bell, Ph.D., Joanna Fiszdon, Ph.D., Jennifer Lynn Zajac, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify cognitive health needs in a variety of patient populations; 2) Identify methods to conduct evidence-based cognitive rehabilitation treatments; and 3) Determine what type of cognitive rehabilitation is best suited for particular clinical situations.

SUMMARY:

Cognitive health is essential for good functioning in the community and typically becomes compromised as a result of affective, substance abuse, psychotic disorder, or age-related disorders. Clinicians require feasible methods to identify when patients have cognitive health needs so that they can appropriately implement treatments such as cognitive rehabilitation (CR). CR is an evidenced-based non-pharmacological treatment. Narrowly defined, it is a set of cognitive drills or compensatory strategies designed to enhance cognitive function or compensate for the impact of impairments on everyday living skills. From the vantage point of the psychiatric rehabilitation field, CR is a therapy which engages the patient in learning activities that enhance cognitive skills relevant to their chosen recovery goals. CR therapies vary in the extent to which they reflect these narrow or broader perspectives but a number of meta-analytic studies have found moderate range effect sizes on cognitive test performance and daily functioning. Reciprocal interactions between baseline cognitive ability, the type of instructional techniques used, and motivation provide some explanatory power for the heterogeneity in patient response to CR. Using didactic instructions, multimedia, case studies, and panel discussion, this interactive session will provide the audience with up to date information about cognition, tools to identify cognitive health needs, methods to promote cognitive health, and available cognitive rehabilitation services.

The Deadliest Drug Epidemic: How Psychiatrists and the Media Miss the Boat on Tobacco Addiction, and What to Do About It

Chair: Michael Brus, M.D.

Presenter: Jill Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify several ways that tobacco addiction can get minimized while making treatment decisions; 2) Discuss issues and barriers that have prevented tobacco treatment from occurring in mental health and addiction treatment settings; and 3) Recognize that knowledge barriers exist for behavioral health providers, including psychiatrists.

SUMMARY:

In recent years, psychiatrists and the media have brought needed attention and resources to the opioid epidemic, which killed 72,000 Americans in 2017. Largely forgotten in this outcry, however, is the ongoing tobacco pandemic, which kills 480,000 Americans a year and accounts for 11.5% of all human deaths. With a greater than 60 percent mortality rate, tobacco use disorder is one of, if not the, deadliest diagnoses in the DSM. Yet abundant evidence shows that, not only is this addiction grossly under-treated, it is often not even considered worthy of clinical focus. This presentation will have two parts. In the first, Dr. Brus will detail the ways that the psychiatric community and the culture at large unwittingly minimize the severity of tobacco addiction. For instance, tobacco use disorder is frequently absent from diagnostic assessments and treatment plans even when assessment narratives clearly mention it. If the addiction is diagnosed, clinicians rarely follow an informed-consent process justifying why treatment was not prioritized, or documenting a patient's capacity to refuse a lifesaving treatment. Only a quarter of U.S. substance-abuse facilities offer nicotine replacement or medication treatment, and two thirds allow tobacco use on their grounds--even as they prohibit use of other drugs with far less morbidity and mortality. Even the language used by the public, clinicians, and researchers alike—"cessation assistance" instead of treatment, "quit date" instead of abstinence date, "smoking" instead

of drug use, "habit" instead of addiction—minimizes the problem. In the second part, Dr. Williams will review strategies for addressing tobacco in behavioral health systems. These include changing policy to reduce the acceptability and availability of tobacco in the environment and training staff to use evidence-based treatments. Despite barriers, behavioral health providers are well-suited to treat tobacco addiction intensively because they have experience and training in treating other addictions and expertise in behavioral therapies. Integrated models are successful for other substance use disorders and can succeed for tobacco treatment as well. Pharmacotherapy is a key component of effective treatment, and psychiatrists and other prescribers lack education about the optimal use of these medications. Myths and false beliefs abound in these settings and derail progress. We will discuss a New York City based project (nyctcttac.org) for training and technical assistance on tobacco addiction. We will lead a discussion with the audience to reflect on current barriers to addressing tobacco use.

The Engagement Challenge: Lessons From a High Utilizer Pilot

Chair: Sabina Lim, M.D., M.P.H.

Presenters: Chris Copeland, L.C.S.W., Ian Arnold Shaffer, M.D., Sam Sarkissian, M.P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the clinical, procedural, and operational challenges of a value-based pilot.; 2) Identify key principles and techniques to facilitate engagement within a diverse group of people with mental illness/substance use disorders.; 3) Understand the overall clinical and psychosocial profile of patients with multi-morbid behavioral health and medical conditions.; and 4) Identify potential alternate solutions to engaging a diverse high utilizer population..

SUMMARY:

New York State is in the midst of transformational change in the delivery of healthcare services. A major focus of this initiative is a fundamental change in the overall delivery of care and reimbursement of services for people with mental illness and/or

substance use disorders. HARP (Health and Recovery Plan) is a total cost of care Medicaid benefit package which began in October 2015 for a subpopulation of beneficiaries with mental illness and/or substance use disorder who have the highest rates of physical and behavioral health service utilization. The Mount Sinai Health System (an eight-hospital academic health care system), the Institute for Community Living (a community-based organization), the Mount Sinai Health Home, and Healthfirst (a payer) have collaborated on a two-year pilot to implement a highly coordinated system of care management and provider collaboration for HARP members. The major goals of this pilot are to reduce excess utilization of acute behavioral health and physical health services, increase utilization of recovery-oriented services, and improve key physical health indicators. We will present the overall model and workflows of engagement and collaboration developed by the pilot network, and present preliminary data on utilization and quality metrics. We will focus on key lessons learned, particularly the crucial process and content of “engagement”, and how we addressed this challenge. We will review best practices in engagement and care management for this population, and how our model has evolved as we identified key operational barriers and better understood the life stories and circumstances faced by our patients. We will review the clinical profiles of our members, as there is significant diagnostic and psychosocial heterogeneity in this high utilizer population. We will utilize case examples and small groups to encourage dialogue and brainstorming, and for participants to share successes and challenges from similar initiatives/pilots.

The Role of Mental Health in Getting to Zero New HIV Infections: The Science, Psychosocial Issues, and Disparities

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

Presenters: Daena L. Petersen, M.D., M.P.H., Carmen E. Casasnovas, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand PrEP [pre-exposure prophylaxis] and the ART's [antiretroviral treatments] that are currently available for PrEP; 2)

Identify the social/ behavioral determinants of mental health causing disparities of HIV infection for men and women of color, including transgender women, and people who inject drugs; 3) Discuss methods to increase awareness about PrEP, ways to access PrEP through appropriate medical/mental health providers, and community education; and 4) Understand the role of PrEP as a prevention strategy for HIV in PWID as well as potential challenges and dilemmas specific to this population.

SUMMARY:

HIV continues to be a world-wide epidemic. In the United States, approximately 40,000 new infections occur yearly, with the major incidence in MSM's (men who have sex with men). Men and women of color are disproportionately infected. The advent of multi drug treatment for HIV that has increased health and longevity among those infected has had the effect of decreasing the sense of fear and anxiety about acquiring HIV as a life-threatening disease. International studies indicate that antiretroviral medication can effectively prevent acquisition by HIV via sexual transmission if taken as prescribed [pre-exposure prophylaxis-PrEP]. According to the CDC, people who inject drugs (PWID) represented 9% of HIV diagnoses in 2016 and PrEP has been recommended as an effective method for the prevention of HIV infection in PWID after international studies demonstrated PrEP as an effective prevention strategy. 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 serologically tested to be HIV negative. Despite these recommendations and PrEP's effectiveness, communities at highest risk continue with low awareness about PrEP and have poorest access to this treatment. In addition, these population-based recommendations do not adequately assess the impact of PrEP on individuals with regards to psychological readiness, capacity for adequate adherence to daily dosing, and potential for increasing risk taking behavior. Antiretroviral therapy for people infected with HIV that suppresses viral replication has already been shown to have a significant impact on reducing the transmission of HIV from HIV infected to non-infected. Concerns have been voiced about spending resources on PrEP

rather than on treatment for those already infected, especially in resource poor nations. This workshop will present a few brief presentations on the science of PrEP, the translation of the research into clinical practice, the psychotherapeutic, social policy issues, and the 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: 1-How effective is PrEP when used in the clinical setting compared to research protocols? What variables in the protocols might not be present in the clinical setting? 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 among a variety of MSM's or PWID? 4- How will resources applied to PrEP affect the access to care and treatment for people infected with HIV? 5-How should psychiatrists and mental health clinicians incorporate PrEP into an ongoing treatment for high-risk individuals? What countertransference issues might arise?

Saturday, October 05, 2019

Augmenting Serious Mental Illness (SMI) Care With Digital Mental Health Tools and Registries: Real World Considerations

Chair: John Torous, M.D.

Presenters: Alexander S Young, M.D., Arthi Kumaravel, M.D., Joseph Ventura, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify at least three use cases for web-based or kiosk tools in the care of patients with SMI; 2) Evaluate and recommend digital mental health tools for patients with SMI, allowing for integration into treatment plans; 3) Assess safety and privacy considerations for digital mental health tools; 4) Access the APA registry and learn how to use included information to help patient care; and 5) Understand the conceptual, professional, legal, and ethical boundaries in using digital mental health tools.

SUMMARY:

As digital health technologies like smartphones, chatbots, smartwatches, and computer-based virtual reality continue to expand and offer potential advantages in the treatment of and recovery from SMI, knowing which tools can help patients and clinicians today is very important. New advances in web-based and kiosk technology for delivering improved services and care will be discussed. Understanding and assessing functional capacity, which is strongly related to daily functioning, can help guide the targeting of these services and interventions. This session will explore a range of new technologies relevant to SMI and outline both their risks as well as benefits as well as examine their conceptual rationale. Considering the unique challenges many patients will face including reduced access to more expensive technologies and lower digital health literacy, this session will explore means to assess patients' interests and understanding of utilization of these new tools within community care approaches. Strategies for informed decision making in selecting digital tools will be discussed and examples provided via didactics / role plays / scenarios offered via small groups. Finally, a discussion of technology implementation, professional, legal, and ethical boundaries will help clinicians understand current potential uses as well as more appropriate versus more risky approaches towards integrating technology in care.

Biopsychosocial Joins Eco-Spiritual to Address the Climate Crisis

Chair: James Lee Fleming, M.D.

Presenter: Jim Antal

Discussants: Lise Conway Van Susteren, M.D., Janet Lisa Lewis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current scientific evidence connecting climate change with serious direct and indirect mental health impacts.; 2) Identify the primary psychological and behavioral drivers of the causes of climate disruption.; 3) Understand the value of medical and mental health professionals collaborating with faith leaders and other community organizations to protect public health from catastrophic climate disruption.; and 4) Identify types of faith community collaborations and

actions likely to help protect the public from catastrophic climate disruption..

SUMMARY:

Extreme natural disasters have resulted in communities and thousands of lives lost at enormous economic cost (~ \$306 billion in 2017) (1). Climate scientists have determined that increased frequency and intensity of weather disasters are causally related to global temperature rise (2,3). Serious mental health consequences of climate change (CC) include trauma from disasters, suicide and violence associated with heat, and neurocognitive impairments due to air pollution. Despite scientific consensus, the public health crisis of CC has been politicized and a prominent "climate denial" narrative exists in this country. The UN IPCC report states that, without major changes in public policy and corporate actions in relation to the use of fossil fuels, the primary driver of global warming, there will be massive social, economic, political, and health crises within the next 20 years (3). This will include more severe and frequent extreme weather events, epidemics of respiratory and infectious diseases, psychological trauma, and widespread loss of homes, property, and lives, leading to widespread social unrest, and mass migration. In other words, dramatic changes to our environment and our lives are inevitable. By 2040 widespread drought, massive famine, and increased international conflict are likely. These major threats to humanity warrant urgent responses from the entire health community. Our code of ethics requires us to "participate in activities contributing to the improvement of the community and the betterment of public health" (4-6). The severity of extreme climate-related impacts requires increased collaboration across all of society. Despite the undeniable evidence of these impending climate catastrophes, the scientific, medical and public health communities have been unable to sufficiently persuade key policy makers of the urgency of action on climate change. Faith-based leaders and their organizations add a degree of moral authority that can complement the scientific authority of health professionals. Reverend Jim Antal has created a model for this collaboration. He recently joined Cardinal Sean O'Malley and 20 other interfaith leaders, along with scientists, to initiate the Massachusetts Science & Religion Coalition (7,8).

This coalition's goal is to link scientific and religious leaders to speak with a united voice to policy makers, elected leaders and the general public regarding the need for immediate and significant action on CC. This presentation will provide the seeds for a similar summit between faith leaders, psychiatrists and public health officials. Rev. Antal recently issued a challenge to the APA, asking that we "amplify our voice, not as one discipline among health professionals", but by contributing our unique insights and vantage point to the advocacy and activism already taking place. This workshop will explore mental health and faith collaboration, specifically as it relates to confronting climate change.

Bridging the Access Gap: Perspectives on Behavioral Health Urgent Care as an Alternative to the Emergency Room

Chair: George L. Alvarado, M.D.

Presenters: Vera Feuer, Anna Kostrzewski Costakis, M.D.

Discussant: Manish Sapra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify current access gaps in existing behavioral health and how these relate to ED overutilization.; 2) Understand unique aspects of behavioral health urgent care models for adults and children, and how these can impact avoidable ED use.; and 3) Understand potential funding and sustainability methods for developing new models of access..

SUMMARY:

Rising rates of ED utilization for psychiatric disorders, a well- documented and persistent trend, comprise up to 10% of all emergency visits. Attendant problems include overcrowding, safety concerns, excessive service utilization, low patient satisfaction, low follow up rates and increased – and often unreimbursed – hospital costs. In the absence of timely access to the effective ambulatory services, many patients end up in the emergency room, even if potentially better served by a lower level of care. However, few intermediate treatment options exist within the mental health service landscape with the potential to fill this access gap left by traditional

outpatient and acute care services. Within this context, Behavioral Health Urgent model has arisen as a promising model, focused on rapid access to treatment, coupled with robust follow up and linkage. Funded through New York State DSRIP Crisis Stabilization Project, two unique programs were developed at Northwell Health, addressing the needs of both adult and pediatric populations. The Zucker Hillside Behavioral Health Crisis Center is an adult walk-in center located in the ambulatory clinic, offering immediate comprehensive psychiatric evaluation and initiation of treatment. The Cohen's Children's Behavioral Health Urgent Care, set up as a step-down from the ED, provides same day evaluations to patients under 18, referred by schools, pediatricians, and the larger community. The session would aim to compare and contrast the two programs in terms of population, setting, staffing, workflow, unique benefits and challenges, stakeholder relationships, clinical outcomes and impact on ED utilization. In addition, the session would seek to explore the unique role of intermediate and transitional care following assessment, for each of the program. Recent data on program effectiveness from participation in the IHI "ED and Upstream" program will also be shared. Participants would be invited to participate in an interactive discussion to identify their own challenges with access- whether from the emergency services or ambulatory side- and identify what interventions might be helpful in addressing the current needs. Pathways for long term sustainability will also be explored, as well as the feasibility of recreating this model in other clinical settings. Participants would be guided through an interactive exercise on how to calculate the ROI for an urgent care center, as well as how to best advocate for service delivery change within their own practice environment.

Building a National Model of Integrated Care and a Partnership Between CHN and ICL

Chair: Gertie D. Quitangon, M.D.

Presenters: Jeanie T. Tse, M.D., Edward Tabasky, M.D., Anna Shapiro, M.D.

Discussant: Robert Hayes, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify innovative models of integrating physical and behavioral health care.; 2) Understand the shared organizational values forming the foundation of the CHN-ICL partnership.; 3) Examine the process of transition from fee-for-service to value-based payment in a fully integrated care delivery system.; 4) Describe the development of an integrated care family and psychiatric nurse practitioner fellowship.; and 5) Discuss integration of a primary care provider in an ACT team..

SUMMARY:

Community Healthcare Network (CHN) is a non-profit organization with twelve Federally Qualified Health Centers (FQHC) in New York City committed to provide healthcare for all and close gaps in mental health treatment by integrating behavioral health in primary care. CHN has implemented innovative programs in collaboration and integration in an effort to assess what model best fits the organization's goals and values. A team of psychiatrists, psychiatric nurse practitioners, behavioral health therapists, social workers and care managers are co-located with primary care providers at each center. Our session will discuss key elements of integrated care systems and describe two models of collaborative care programs in the network, the IMPACT model and the Continuum-based framework, providing treatment interventions for common behavioral health conditions, primarily depression and anxiety. CHN joined forces with Institute of Community Living (ICL) to build a national model of integrated care and increase access to physical and behavioral health care for populations with a wide range of type and severity of behavioral and physical health symptoms. ICL is a human services agency that provides behavioral health, social services and housing for children and adults with serious mental illness, substance abuse, and developmental disabilities. Our session will examine the integration of CHN's FQHC at the East New York Health Hub (Hub) where an array of ICL programs are stationed including an Article 31 clinic, a PROS program, a family resource center, and several ACT teams. The Hub is located in East New York, Brooklyn, a neighborhood that has struggled with higher rates of poverty, violence, chronic disease such as heart disease and diabetes, and

psychiatric hospitalizations compared with the rest of the city. We review the evolution of the CHN-ICL partnership and a shared vision of full integration and a path to value-based care. Participants will learn our shared values, defined as Trauma-informed, Recovery-oriented, Integrated, Person-centered care (TRIP), and understand how these values shape clinical practice and desired outcomes. Our session will describe our experience of integrating primary care in assertive community treatment services.

Children's Service Integration: A Framework for Scaling Evidence-Based Practice and Practice-Based Evidence to Support Resilience in Children and Families

Chair: Tiberiu F. Bodea-Crisan, M.D.

Presenters: Teri Stanley, Diane Lyle

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the Children's Service Integration Framework and Clinical Model platform developed to comprehensively address the needs of children and families; 2) Demonstrate the key component of the model through participation in a case study and example discussion applying the clinical model; 3) Discuss the outcomes achieved in the implementation of the model; and 4) Understand the scalability of strategies and application of the framework and clinical model to participants' practice.

SUMMARY:

Community Care Behavioral Health Organization, a non-profit behavioral health managed care organization, has created a unifying framework for children's services; the Children's Integrated Services Framework (CSI). The framework is based upon a holistic approach guided by the philosophy that the following core principles should be incorporated into all children's behavioral health services: true affirmation of families, established clinical home, defined clinical model, relevant evaluation framework, viable physical health/behavioral health integration, and continuous workforce development. These six principles are interlocking and mutually reinforcing. We have operationalized and scaled this integrative framework both through the

development of innovative community-based service delivery models such as our Community-School Based Behavioral Health (CSBBH) teams and through its adoption and implementation across levels of care within various children's behavioral health services. The faculty will review each component of the framework and discuss the clinical model in depth. The faculty will then lead an interactive discussion of the clinical model with case presentation and demonstrate application of the model in clinical practice. The CSI framework and CSBBH service has been brought to scale across Pennsylvania with 69 teams serving over 2,000 children across 22 counties. The framework and clinical model have been adopted in other community-based services for children and families and implementation with Psychiatric Residential Treatment Providers is underway in 2019. The faculty will share strategies used to successfully scale the model and support implementation through learning collaboratives, provider faculty collaborative training, and other strategies to support skill development and competency building within the workforce and the use of a value-based payment model to provide sustainability. Annual evaluations of the effectiveness of these interventions reflect meaningful clinical outcomes with consistently positive results. A recent study included 1308 Medicaid-eligible youth participating in CSBBH. Caregiver and teacher report of child and family outcomes and administrative claims data were assessed over 24 months. Repeated measures multivariate analysis indicated that ratings for family and child functioning significantly improved over time ($p < .0001$ for both) as did ratings of therapeutic alliance ($p = .002$) and caregiver- and teacher-reported ratings of total difficulties ($p < .0001$ for both). The faculty will present findings and facilitate discussion of applicability of the framework and clinical model to their practice. Topics: service transformation, population health management

Cont(rolling) the Dice: Suicide, Violence, and Therapeutic Risk Management

Chair: John S. Rozel, M.D.

Presenters: Layla Soliman, M.D., Abhishek Jain, M.D., James Colin Rachal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of evidence based risk factors for suicide and violence; 2) Incorporate social and psychiatric factors into clinical risk assessments; 3) Discuss psychosocial interventions to reduce risk; 4) Discuss pharmacologic interventions to reduce risk; and 5) Document risk assessment and steps taken to mitigate risk.

SUMMARY:

Suicide and violence represent two of the most common concerns for presenting for clinical attention, and two of the leading causes of action in malpractice claims against psychiatrists. Though risk assessment has long been a core clinical skill, there remains considerable variability in how it is done and/or documented, prompting regulatory bodies such as Joint Commission to advocate for uniform assessments. Regardless, most psychiatrists agree on the importance of documenting a concise risk assessment. The presenters have forensic and/or administrative backgrounds, with experience practicing in a variety of treatment settings, providing clinical consultation to assist colleagues in risk assessment and mitigation, making inpatient units safer, and assessing risk and malpractice liability in the legal realm. Two presenters have provided numerous clinical consultations for risk mitigation, bringing a unique perspective to the clinical challenge of risk assessment. In this interactive session, we discuss using available evidence to assess patients' risk for suicide and/or violence, and integrating these assessments into clinical care. This includes assessing risk related to specific diagnostic categories, such as Schizophrenia/psychosis, substance use, and mood disorders. We will also link the risk assessment to targeted interventions aimed at modifiable risk factors. Ideally, a treatment plan includes using psychosocial interventions such as peer supports, ACT teams or other resources, and engaging natural supports to build a "safety net" in the community. Pharmacological interventions also play an important role in achieving and maintaining stability, and we will discuss the evidence for different classes of medication. We will also discuss compliance issues and how those might be addressed within the physician-patient relationship. These interventions

should be undertaken in partnership with the patient, to the maximum extent possible. Such partnership primarily manages the patient's risk of an adverse outcome, and mitigates provider liability. Therapeutic risk management, a concept introduced by Robert Simon, MD and Daniel Shuman, JD, encourages clinicians to "achieve optimal alignment between clinical competence and an understanding of legal concerns applicable to psychiatric practice." (Simon and Shuman, 2009). The proposed approach aims to answer that call. The final part of the presentation focuses on two of the most powerful risk management tools, consultation and documentation. Clinical consultation, or second opinions, can lend valuable insight into what interventions may help a given patient. Such consultations also demonstrate that the primary team is taking extra care to help the patient achieve the best outcome possible. Documentation preserves a record of such efforts, and of the team "thinking out loud," providing a valuable resource for transitioning care, or in the event of an adverse outcome, responding to a malpractice claim.

Designer Drugs of Abuse: History, Clinical Assessment, and Psychiatric Management

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

Presenters: John Douglas, M.D., M.B.A., Isabella Morton, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the signs and symptoms associated with intoxication by designer and novel synthetic intoxicants.; 2) Organize and focus a differential diagnosis when intoxication is suspected despite negative toxicology results on routine urine and serum screening; 3) Develop and execute a treatment plan for managing intoxication by designer and novel synthetic intoxicants.; and 4) Discuss the role of internet communications in the emergence and distribution of novel and designer drugs of abuse..

SUMMARY:

Designer drugs of abuse are psychoactive substances that are often synthetically derived from known stimulants, hallucinogens, or opiates but are usually unregulated due to their novel chemical structures.

Some of the more well known of these new substances are cathinone derivatives (“bath salts”), synthetic cannabinoids (“K2 /spice”), piperazine derivatives (“Legal Ecstasy”), methoxetamine (“Legal Ketamine”), salvia divinorum, and mitragynine (“Kratom”). Nonpharmaceutical fentanyl analogues and the well-known synthetic club drug intoxicants gammahydroxybutyrate (GHB) and ketamine (“Special K”) are not detected on routine point of care toxicology tests. Over the past few years there has been a rapid proliferation of designer intoxicating substances. This panel will review the recent surge in use of these new drugs including a discussion of their prevalence, pharmacokinetics and pharmacodynamics. This session will introduce these intoxicants’ street names, subjective effects, and physical signs. The role of internet communications in their production, sale, and promotion will also be emphasized. Presenters will discuss developing a differential diagnosis when intoxication by these agents is clinically suspected in practice. General approaches to managing the effects of acute intoxication by one or more of these substances will be presented, including both monitoring and treatment strategies. Given the rapid growth in the use of these substances and their increasing appearance in clinical presentations, a review of our current state of knowledge has important implications for educators, clinicians, and policy makers. This session will use a case example to illustrate clinical assessment and treatment options for these designer drugs of abuse. Audience members will be invited to participate in a facilitated case discussion and asked to identify a differential diagnosis, identify what additional data they would seek to help narrow their differential diagnoses, and select which treatment approaches they would utilize to manage acute intoxication and potential long-term side effects. A facilitated discussion involving the presenters and session attendees will critique the assessment and management of the case along with highlighting critical implications for clinical practice, research, and public health. The session will conclude by asking the session participants to reflect upon the knowledge they learned, skills they acquired, and attitudes that were changed.

Film Short of Dr. Carl Bell: In Remembrance

Chair: Helena B. Hansen, M.D., Ph.D.

Presenters: Altha J. Stewart, M.D., Danielle Hairston, M.D., Danielle S. Jackson, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and improve mental health disparities in the community; 2) Recognize how to bring new innovations into a variety of treatments to improve patient care; and 3) Advance and update skills in community psychiatry treatment.

SUMMARY:

This media session will screen portions of a 2018 interview with Dr. Carl Bell about the contributions of Black psychiatrists to the APA, and about his own work against structural racism and racial mental health inequalities. The screening will be followed by a panel discussion of the contributions of Dr. Bell to the field of psychiatry. Panelists include the immediate past president of the APA, Dr. Altha Stewart, the chair of the APA Black Caucus, Dr. Danielle Hairston, Dr. Helena Hansen of the Council on Minority Mental Health, and the APA Black Caucus RFM/ECP representative, Dr. Danielle Jackson.

Formalizing the Curbside: Electronic Consultation in Mental Health

Chair: Christopher Thomas Benitez, M.D.

Presenters: Lori E. Raney, M.D., Matthew S. Duncan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will be familiar with current electronic consultation models and factors that impact their implementation and sustainability; 2) At the conclusion of this session, participants will be aware of the roles of both the primary care provider and psychiatric consultant in the electronic consultation submission and dialogue; 3) At the conclusion of this session, participants will be able to describe potential medical-legal issues related to electronic consultation within and across state lines; and 4) At the conclusion of this session, participants will understand existing evidence for use of an

electronic consultation model applied in psychiatric care.

SUMMARY:

Many patients do not receive needed mental health treatment (1), despite the fact that mental health conditions top the list of most costly medical conditions in the United States (2). Efforts to improve access to mental health care are limited by structural barriers and patient/provider perceptions (1). Primary care clinicians provide most mental health treatment for these conditions (3, 4), underscoring the importance of collaboration between primary care providers and psychiatrists (4) and highlighting the need for care delivery models to manage behavioral health conditions across populations. Electronic specialty consultation has been widely implemented in diverse settings (5) and has the potential to enhance access, care coordination, provider communication, and population management. However, these potential benefits are accompanied by implementation challenge and limited acceptance by the medical community (5). While electronic consultation expanded in the medical specialties over the past decade, its use has been less well-described in behavioral health management despite its potential to support delivery of behavioral health treatment by primary care providers. Through electronic consultation, general medical providers may become better equipped to manage their patients' mental health needs themselves (6) and make more informed referrals to the appropriate behavioral health providers (including case managers, social workers, psychologists, and psychiatrists). This session will offer participants the opportunity to explore specifics of electronic consultation for behavioral health conditions in three different programs, including a well-established program in a large public health system in Los Angeles that has processed nearly 15,000 consultations since launch in 2015, a New Hampshire program at a tertiary academic medical center in a rural and geographically dispersed area that launched in 2016 and has completed more than 350 consultations, and a new program in Colorado that is preparing to launch. Presenters from the three programs will review electronic consultation models, describe operational considerations relevant to the

implementation and sustainability of electronic consultation initiatives, and use sample consultations to foster discussion about the use of electronic consultation systems for behavioral health.

Good Psychiatric Management of Borderline Personality Disorder: What Every Clinician Should Know to Meet Public Health Demands

Chair: Lois W. Choi-Kain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current demand and supply problems in evidence based treatments for borderline personality disorder (BPD); 2) Identify the evidence base for generalist approaches to managing BPD; 3) Describe the core features of the Good Psychiatric Management (GPM) approach to BPD; and 4) Describe the application of core principles of GPM to inpatient, emergency room, and outpatient settings.

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.

Mass Violence and Behavioral Health Services: How Organizations Can Understand, Prepare for, Respond to, and Help Prevent Attacks in Their Community

Chairs: John S. Rozel, M.D., Joseph John Parks, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Contrast the trends of mass violence/shootings compared to other types of violence; 2) Evaluate current evidence about the role of mental illness and other factors in mass violence; 3) Explain the impact of mass violence on communities and behavioral health organizations; 4) Identify opportunities for behavioral health organizations to work with communities before and after mass violence; and 5) Explain how behavioral health professionals can use threat assessment and management to stop attacks before they happen.

SUMMARY:

In 2018, the National Council on Behavioral Health's Medical Directors' Institute convened an expert panel to address issues relating to mass violence from the perspective of the Council's constituency and membership: 2800 organizations providing clinical behavioral health and addiction services across the United States. The Medical Directors' Institute represents the medical and psychiatric leadership of those organizations. The expert panel was charged with summarizing critical data relating to this complex phenomena and to provide specific recommendations for action by membership organizations and policymakers. Mass shootings impact behavioral health organizations in a variety of ways including care for survivors and impacted communities, the potential for violence in or against clinics and hospitals, stigma from misperceptions about the intersection of violence risk and mental illness, and, indeed, care for a subset of patients at elevated risk for engaging in violence. While most forms of violence have decreased in the US over the past generation, mass violence appears to be increasing. On the heels of the 2018 Institute on Psychiatric Services, The National Council convened a team of subject matter experts from a variety of

disciplines to discuss a number of issues including quantifying mass violence, understanding risk factors and the role of mental illness, investigating strategies for the prevention of targeted violence including threat assessment and management, family perspectives, journalism and media issues, the role of schools and primary care providers, and extricating issues relating to high risk individuals and firearms. The panel met over two days and developed a number of recommendations for screening and intervention across a number of settings but with a particular focus on drawing behavioral health and substance use professionals into the processes related to mitigating risk. Working with a team of technical writers and leadership from the Medical Directors' Institute, the team developed a report covering their findings and recommendations. Every effort was made throughout the process to emphasize the role of recovery, to mitigate stigma, and to recognize and respect the impact of these events on the victims, survivors, and families including the families of perpetrators. This presentation will briefly outline the process used to develop the report, review the recommendations themselves, and explore opportunities for improving collaboration across disciplines to broaden the resources available to threat assessment professionals. Priorities and considerations for mental health professionals and administrators to prepare their programs and teams to better respond to the risk of mass violence will be shared.

National Institutes of Health Town Hall: Hear From Leadership

Chair: Saul Levin, M.D., M.P.A.

Presenters: Robert Heinssen, Ph.D., Patricia A.

Powell, Ph.D., Carlos Blanco-Jerez, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate new research and treatment strategies into clinical practice; 2) Identify and improve mental health disparities in the community; 3) Recognize how to bring new innovations into a variety of treatments to improve patient care; and 4) Advance and update skills in community psychiatry treatment.

SUMMARY:

Improving mental health services depends on rigorous science which is often supported by the National Institutes of Health. Come meet leadership from the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at this interactive town hall session with: NIDA Director of the Division of Epidemiology, Services & Prevention Research Dr. Carlos Blanco, NIMH Director of the Division of Services and Intervention Research Dr. Robert Heinssen, and NIAAA Deputy Director of the National Institute on Alcohol Abuse and Alcoholism Dr. Patricia Powell. Drs. Blanco, Heinssen and Powell will provide brief updates about their institute's scientific priorities as they relate to behavioral health, and the session will then include an open discussion with the audience. Science is moving forward quickly and making sure that the topics and issues of importance to you are addressed is key. Bring questions for the open discussion. NIH wants to hear from you!

Open Dialogue-Inspired Health Systems in the US: Successes, Challenges, and Opportunities

Chair: Robert Osterman Cotes, M.D.

Presenter: Sandra Steingard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the key principles of Open Dialogue; 2) Identify strengths and challenges to implementing Open Dialogue as experienced by five programs.; and 3) Discuss aspects of current behavioral health service structure in the US that may facilitate or inhibit "being dialogic."

SUMMARY:

Open Dialogue, initially developed in Finland, is a person-centered approach to working with individuals in the midst of a mental health crisis. It emphasizes immediate access to help, shared decision-making, and engagement of the family/network. Open Dialogue has shown promising results in initial, largely European studies, and the first large scale controlled trial is ongoing in the UK. In this session, we will introduce the audience to Open Dialogue and will discuss its origins and guiding

principles. Can principles of Open Dialogue influence US health care settings? We will present a summary of the work that has been done in the US in five different settings, which include locations in New York, Massachusetts, and Georgia. For each of these examples, the presenters will discuss how Open Dialogue has influenced their work and what challenges they have faced. Participants will be encouraged to critically think of barriers in our current system when implementing services that are informed by Open Dialogue and ways that they might be overcome.

Prescribe and Bill Quickly: The Role of the Psychiatrist in a Community Mental Health Clinic

Chair: Claudine Elaine Jones-Bourne, M.D.

Presenters: Rachel Melissa Talley, M.D., Dianna Dragatsi, M.D., Maria Mirabela Bodic, M.D.

Discussant: Jonathan Hertz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the various roles psychiatrists can have in a community mental health clinic as described in a Systems Based Practice framework; 2) Identify the barriers preventing psychiatrists from fulfilling their various roles; and 3) Identify ways in which psychiatrists can assert their utility in their various roles.

SUMMARY:

In the current fast-paced healthcare environment, with EMRs, billing and insurance reviews, community mental health clinics face real challenges in breaking even in the context of serving primarily Medicaid populations. This and other factors have placed growing demands on psychiatrists for productivity and efficiency, resulting in less and less time spent seeing patients. In response to this pressure, some community psychiatrists have to assume the role of "prescribers" and prioritize "med checks" over other therapeutic modalities or administrative and teaching responsibilities. Although prescribing medications is paramount to a psychiatrist's job, this is only one aspect of the more complex and productive roles they can assume in the community mental health clinic setting. This "top of the license" view of the psychiatrist's contributions is likely to have a negative impact on patient care, and on the

physicians' wellness and engagement, leading to difficulties with recruitment and retention in the public sector. A Systems Based Practice (SBP) approach to psychiatric care has been previously proposed as a framework for considering the various roles a psychiatrist could assume at any given time to address the needs of their patients. This approach delineates 4 key domains: patient care advocate, team member, information integrator, and resource manager. During the session, presenters will use a vignette of a complex but typical clinic patient (severe mental illness, medical problems and psycho-social stressors) to walk the audience through the SBP approach as a model framework for thinking expansively about the role of the psychiatrist. Participants will collaborate in small groups to consider practical, real-world ways they could step outside of the boundaries of prescribing medications and envision the 4 roles to develop the best treatment plan for their patients, teams and clinics. Presenters will draw on audience's experience to discuss other situations in which this framework could broaden the contribution of the psychiatrist, and will brainstorm concrete, feasible ways to implement the suggestions within the time and efficiency constraints of the community mental health clinic setting.

Psychiatry at the Border: Integrating Mental Health, the Law, and Public Awareness

Chair: Divya Chhabra, M.D.

Presenters: Eric Rafila-Yuan, M.D., Pamela Carolina Montano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand specific stressors faced during the immigration process as well as the consequences of detainment and family separation, and name factors that influence resilience; 2) Review the changing landscape of US immigration policy, including the border, family separations, and asylum, with a focus on changes made by the Trump administration; 3) Understand how various fields such as law and journalist interface with the immigration and border crises; 4) Discuss clinical case studies involving undocumented immigrant families and be able to demonstrate culturally, structurally, individually, and trauma-informed

techniques; and 5) Appraise the utility of organized medicine and the role of mental health professionals can play in the political process, effective public policy, and in public awareness.

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. 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 incorporate section on detainment and family separation at the border. Second, we will discuss current policies regarding undocumented immigrants including those on family

separation/re-unification, asylum, and detainment. We will hear perspectives from multiple professions, including a lawyer and a journalist, on how they interface with the crisis at the border, and how we can contribute to their field of work to advocate for this population. 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 role mental health professionals in influencing public awareness, effective public policy, and advocacy.

Psychopharmacology and Ethnicity

Chair: 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.

SAMHSA Technology Transfer Center (TTC) in Addiction, Mental Health Services, and Prevention

Chair: Humberto Carvalho

Presenters: Laurie Krom, Heather Gotham, Holly Hagle, Tristan Gorrindo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the new training and technical assistance programs available from SAMHSA; 2) Locate resources and informational materials related to substance use disorders and mental illness treatment; 3) Know how to access the SAMHSA evidence bases practices resource center; 4) Know how to access training and technical assistance from the Technology Transfer Centers (TTC) Program; and 5) Know how to access training, consultation and resources from the SMI Adviser network.

SUMMARY:

This session will introduce the New SAMSHA TTC's and SMI Adviser. 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. The SMI Adviser offers expert consultation services and learning opportunities nationwide to support clinicians—including physicians, nurses, psychologists, recovery specialists, peer-to-peer specialists, and others—who provide evidence-based care for individuals with SMI.

Screening for Depression in Pregnancy: There's an App for That

Chair: Sarah Ricketts, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the rationale and recommendations for universal screening for depression both during pregnancy and post part; 2) Appreciate the differences in screen positive rates between verbal, printed, and in-app screening; 3) Review barriers to self-report of mental health symptoms by pregnant women, and consider ways to overcome them; 4) Recognize the value of smartphone apps to provide health and self-management information to a safety net population.; and 5) Consider the engagement value of a bidirectional chat feature in the app.

SUMMARY:

Depression during pregnancy or after delivery causes significant adverse biological and behavioral outcomes for mothers, fetuses, children, and families. Routine screening of women both during pregnancy and postpartum is recommended by the American College of Obstetrics and Gynecology as well as the USPSFT; however routine screening is rare outside academic medical settings. Recognizing the value of smartphone applications to provide

health and self-management information. we have developed, implemented and studied the utilization of an app which includes depression, substance use, and social determinants of health screening interposed between short articles, delivered weekly, about pregnancy, fetal development and wellness. The articles are written in simple language and are without cultural bias. They are designed to increase medical literacy about pregnancy. The app, titled HealthyMoms also contains a bidirectional chat feature. We have implemented the HealthyMoms application at two Montefiore Medical Center general OB clinics in the Bronx. Women aged 18 and older, who were under 28 weeks gestation, owned an Android or iOS smartphone, and were literate in either English or Spanish were eligible. Possible enrollees were identified on the daily rosters of the clinic and were offered enrollment either in person in the clinic or by telephone. Women who were interested and consented were entered into the app dashboard, and assistance was provided in downloading and using the app features PHQ 8 depression screens are sent to participants in each trimester and in the first and third month postpartum. Substance use and social determinants screening are sent initially and after 6 months of enrollment. Women who screen positive for depression and/or substance use are referred for telephonic evaluation by team licensed mental health clinicians. Participants are provided with information about their symptoms and are given treatment options, which include referral for face to face treatment or no cost telephonic psychotherapy. If a participant elects not to enter treatment, the clinician makes monthly check in calls, and PHQ 8 questionnaires are sent monthly. Care managers connect participants with appropriate agencies to help with housing, food, legal or safety needs. 100 participants have been enrolled in the project. 66% of the women approached have agreed to participate and 75% have been active in the application. 60% have completed at least one PHQ 8 screen. The screen positive rate of 10% is concordant with prospective research studies and significantly higher than either verbal or on paper screen positive rates in a large NYC cohort. We have also completed semi-structured interviews with participants regarding concerns about reporting mental health symptoms during pregnancy either to

their provider or in the app. These data shed some light on the effects of stigma and medical mistrust on rates of screening positive

SMI, Cardiometabolic Risks, and Accountable Care Organizations

Presenter: David C. Henderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand guidelines to monitor and address cardiometabolic risks in SMI patients; 2) Understand models to address these comorbidities in the SMI population; and 3) Understand the importance of addressing SMI and cardiometabolic risks in the ACO model of care.

SUMMARY:

Severely Mentally Ill (SMI) patients have an increased morbidity and mortality compared to the general population. They have a shorter life span and are at increased risk for CVD related to increased incidence of diabetes, hypertension, smoking, poor diet, obesity, dyslipidemia, metabolic syndrome, and side effects of antipsychotic medications, as well as low levels of physical activity. Over the last 20 years there has been an increased awareness and numerous guidelines to help clinicians monitor and address these issues. The actual adherence to these guidelines is lagging. As organizations move towards an Accountable Care Organization (ACO) approach, this area is critical as SMI patients have a high prevalence in the top utilizers of health care expenditures due to both medical and psychiatric services. New models to address these comorbidities in the SMI population will be explored.

So You Want to Build a Crisis System... Now What? Creating a National Standard for Implementing Crisis Services

Chair: Margaret E. Balfour, M.D., Ph.D.

Presenters: Kenneth Minkoff, M.D., Michael A. Flaum, M.D.

Discussant: Jacqueline M. Feldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the underlying

principles and goals of a crisis system; 2) Describe core components of a robust crisis continuum; 3) Discuss strengths and limitations of crisis services in his/her own community; and 4) Apply lessons learned to his/her own community.

SUMMARY:

Across the country, there is increasing interest in building more robust behavioral health crisis services. States, counties, and others are investing in these services in order to provide a better experience and treatment for people experiencing a mental health or substance use crisis, relieve burdens on emergency departments and jails, and more efficiently use limited funds and resources. However, no national standard exists for crisis services, and thus communities are left to figure out how to create these services on their own. To address this growing need, the Group for the Advancement of Psychiatry (GAP) Committee on Psychiatry and the Community has created a guidebook outlining the elements of an ideal 21st century crisis system. This guide not only outlines the recommended services and competencies, but also addresses structural and systemic aspects such as governance, financing, policy, and performance metrics. It is meant to serve as a resource to service providers, payers, governmental entities, and policymakers. In particular, we hope it will inform the new Interagency Serious Mental Illness Coordinating Committee's (ISMICC), which was created by the 21st Century Cures Act, in their call for federal standards for crisis services. This workshop will describe the core elements of the guidelines and how/why they were created. Then, we will illustrate the practical need and potential application for such guidelines. As a case example, we will discuss the ongoing efforts to build a new network of crisis centers mandated by the state legislature in Iowa, where local provider agencies are grappling with basic practical issues such as program design and scope, oversight, staffing, physical layout, etc. Finally, we will provide the opportunity for participants to provide feedback and discuss specific issues from their own communities with our expert panel. Key findings from the workshop will be incorporated into the final version of the guidelines.

The Impostor Syndrome: International Medical Graduates Navigating Immigration Challenges and Beyond

Chair: Lama Bazzi, M.D.

Presenters: Elie G. Aoun, M.D., Ali Maher Haidar, M.D., Muniza A. Majoka, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the “Impostor Syndrome” in general and how it affects IMGs in psychiatry residency in particular; 2) 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) Understand how acculturation and assimilation play into IMGs learning the American health care system; 4) Appreciate the key role IMGs play in providing healthcare to patients living in under-served areas; and 5) 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.

Treating Intellectual and Developmental Disability Across the Life Cycle: Collaborative Care Models to Improve Behavioral and Primary Care Outcomes

Chair: Debra S. Rosenblum, M.D.

Presenters: Lee Adam Robinson, M.D., Laura Gaugh, Ph.D.

Discussant: Nicholas Carson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide perspective on the unique psychiatric, medical, and systemic needs associated with children and adults diagnosed with Intellectual and Developmental Disabilities; 2) Recognize disparities in access to care for individuals with ID/DD; 3) Understand how poor health

outcomes occur in behavioral and primary care settings for this vulnerable population throughout the life cycle; and 4) Demonstrate ways in which psychiatrists can improve access, experience, and outcomes for individuals with ID/DD by working in collaborative healthcare models.

SUMMARY:

Individuals with intellectual and developmental disabilities (ID/DD) face complex barriers in their access to behavioral health and primary care. Health care providers report feeling unprepared to support this population, and individuals with ID/DD often experience care fragmented across many providers and systems. While community services and supports for individuals with disabilities like Autism Spectrum Disorders (ASD) have expanded dramatically in recent years, disparities in access to those services remain substantial across childhood. As youth transition to adulthood, poor coordination between systems and limited numbers of adult providers with specialized expertise introduce additional barriers to care. Adults with ASD and ID experience high rates of unemployment/underemployment, higher comorbidity with psychiatric symptoms including mood and anxiety disorders and overall poor health outcomes, including earlier morbidity than their non-developmentally disabled peers. Adults with Intellectual Disabilities are paradoxically undertreated and over-medicated for behavioral health issues. Child psychiatrists and psychologists are uniquely trained and positioned to partner with families, and collaborate with primary care and adult psychiatry to improve medical and behavioral outcomes for individuals with developmental disabilities. Our session will introduce two outpatient programs at the Cambridge Health Alliance (CHA) that are dedicated to supporting individuals with developmental disabilities. Through a mix of case presentations, quality improvement and research findings, presenters will outline ways in which practitioners can enhance clinical skills and partner with primary care to more effectively work directly with this under served population, improve patient quality of life, and improve health outcomes. The two child psychiatrists and pediatric neuropsychologist who staff the Clinic for Healthy Child Development work to reduce wait-time to

diagnosis and to provide ongoing support and consultation to primary care and psychiatry staff and trainees for children and youth. Through the DANAA clinic for Developmentally and Neurologically Atypical Adults, the founding child psychiatrist provides direct psychiatric care to developmentally disabled adults and consults with primary care about behavioral health issues and mechanisms for improving patient experience of care in the primary care setting. The discussant will describe how these two clinical programs are valuable examples of patient-centered care that rapidly address entrenched disparities in diagnostic and clinical outcomes. He will note how such programs require, and enable, links to community programs and agencies that provide complementary services for such patients. As such, they demonstrate how health services in the era of Accountable Care Organizations can leverage such networks to improve population health.

Women in Psychiatric Leadership: Our Field's Experience With the Glass Ceiling

Chair: Luming Li

Presenters: Kimberly Ann Yonkers, M.D., Ilse R. Wiechers, M.D., M.H.S., M.P.P., Anita Everett, M.D., Ismene L. Petrakis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Share stories of women in administrative, research, educational, and clinical leadership roles and specific experiences associated with each role; 2) Discuss challenges and complexities of academic promotion and career advancement related to women; 3) Identify possible barriers and suggested solutions for engaging women in leadership roles at different career points; and 4) Detail diversity of roles within psychiatry for women leaders and how to think about achieving work/life balance.

SUMMARY:

The presence and advancement of women in leadership is an increasingly important topic in psychiatry and other subspecialties. Studies show that women in leadership roles help promote problem-solving, trust, fairness, teamwork, and demonstrate better performance for organizations.

Leadership roles can also provide much-needed personal fulfillment for women leaders. However, in medicine, there is a scarcity of women at a senior level, with few women attaining positions as chairs of academic departments and as healthcare executives. Similarly, women faculty who are full professors represent only 13% of all full-time faculty, compared to 30% for their male counterparts. In a study about high impact psychiatric publications, women contributed to approximately 33% of lead authorships in leading journals, and composed of 25% of the editorial boards. Since publication in academic journals is often connected to academic promotion, these statistics are a stark reminder of the gender inequity that continues to exist. There are a variety of reasons why women may not ascend and instead avoid leadership roles: 1) difficulty balancing work and home life; 2) lack of mentorship and training; 3) society and systemic perceptions about what a “leader” should look like; 4) women’s methods of communication, which are perceived as different than men’s; 5) perception of women as “nurturers” and not “leaders”; and 6) women’s struggle negotiating for jobs and pay. In this session, female psychiatrists in leadership roles will share information and stories about their career journeys, and discuss about salient points important in their career growth. Speakers in the panel have experience in psychiatry leadership roles within research, education, clinical, and administrative contexts, and represent women with differing levels of experience. Important values and competencies described will include building a network inside and outside of the home institution, finding mentors and sponsors, using peer support, asking for part-time leadership roles, being transparent about leadership interest, asking for career development funding, connecting with professional organizations, as well as navigating organizational and team complexity. Additional topics will include ongoing personal and institutional work to promote and facilitate a cultural change to help sponsor and mentor other women. In addition, the panel speakers will share candidly about difficult leadership decisions, not taking on too much all at once, and managing work-life balance. Finally, the panel will discuss about barriers in their career paths, and ideas for overcoming setbacks and building confidence in a resilient manner.

WPA’s Mission, Vision, and Action Plans

Chair: Afzal Javed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Updates about WPA plans; 2) Setting guidelines for collaboration; and 3) Linking with objectives of national professional associations.

SUMMARY:

WPA is an association of national psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 138, spanning 118 different countries and representing around 250,000 psychiatrists from all over the globe. WPA’s core mission is to promote the advancement of psychiatry and mental health for all people of the world. This mission is achieved by increasing knowledge and skills about mental disorders, encouraging the highest possible standards of clinical practice, advocating for the dignity and human rights of the patients and their families, and to uphold the rights of psychiatrists through facilitating communication and assistance especially to societies who are isolated or whose members work in impoverished circumstances. WPA achieves these objectives by organising meetings, arranging special discussion groups and formulating guidelines, position statement and issuing professional directions for its membership. This presentation gives an overview of the vision, mission and philosophy of WPA work with a special emphasis on the current action plan (2014-17). Salient features of current plans will be discussed giving further details of the current work of different WPA components. The presentation will also provide a general framework of WPA functioning and would argue for promoting and strengthening the current initiatives getting further support from psychiatrist community.

Sunday, October 06, 2019

Changing the World: Implementation of Universal Co-Occurring Capability for People With Co-

Occurring MH/SUD in the 7 County Mid-Hudson Region of NY

Chair: Kenneth Minkoff, M.D.

Presenters: Stephanie Marquesano, Marcie Colon, L.C.S.W., Michael Orth, Christie Anne Cline, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand the importance of a systemwide approach to integrating MH and SUD services; 2) To learn the six evidence based principles of integrated treatment, and the associated interventions; 3) To identify specific strategies for using CQI to improve integration in any organization; 4) To become familiar with how to implement systemwide integration in a multi-county regional system; and 5) To understand in detail the characteristics of a co-occurring capable adult or child MH or SUD program.

SUMMARY:

Individuals and families seeking behavioral health services have complex needs, including co-occurring mental health, trauma, substance use, health, cognitive, and other human service challenges, and providing integrated services to meet those needs is a priority. The presence of co-occurring MH/SUD is particularly prevalent – and challenging – in minority populations, and results in poorer outcomes and higher costs, in health, criminal justice, and human service settings. In recent years, the focus of integration of efforts has been on the integration of behavioral health (BH) and health, leading to the impression that the “BH” (MH + SUD) integration has been accomplished. This is however far from the case, and the recent opioid epidemic has made attention to this issue even more pressing. This workshop addresses this issue head on by describing implementation of a framework for integration of services within base resources (the Comprehensive Continuous Integrated System of Care) in a large and diverse multi County regional system in NY State. The goal of the session is that participants leave with concrete next steps about how to improve integration of SUD and MH in their own settings. The workshop begins with specific principles and EBP interventions for integrating MH and SUD in any setting for any population, so all programs and staff become “co-occurring capable”. Specific practices

addressed in the change process for people with co-occurring MH/SUD (including OUD) include welcoming and engagement, screening and identification, integrated teamwork, integrated assessment and service planning, stage matched treatment, medication assisted treatment, individual and group skill building, and peer recovery support. The next session is presented by a family member who established a system transformation project for co-occurring disorders after the death of her son and will illustrate how grassroots advocacy has created energy for involvement of county leaders and providers in the entire region. The third session will describe the progress made by one of the seven counties (Westchester - the largest county), and how that county has partnered with its providers and payers, as well as with other counties to create a regional learning community for change. The final presentation will discuss how the Mid-Hudson regional integration project illustrates best practices for working within very limited resources to engage an entire system in making progress in integrating services, using a framework of customer-oriented continuous quality improvement (CQI), and illustrates the basic steps, tools, and strategies for inspiring all levels - region, counties, providers, advocates - to get organized, identify change agents, and make measurable progress in implementing integrated services. The “12 Steps” of integration for programs, agencies, and systems, and how those are applied to practice improvement, will be illustrated.

Improving Access Through a Proactive Behavioral Health Team’s Collaborative Consultation Model

Chair: Marisa Schwartz, M.S.N.

Presenters: Omar Mirza, D.O., Michael Herscher, Mather R.D. Jogendra, M.D., Victoria Azzopardi

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of multidisciplinary and collaborative management of psychiatric conditions among medicine patients; 2) Understand the differences between Behavioral Health Team models and traditional psychiatric consultation models; 3) Provide examples of a multidisciplinary approach to manage the psychiatric needs of an acutely medically ill patient; and 4) Appreciate the impact of Behavioral Health Team

models on staff empowerment and various metrics such as LOS and readmission rates.

SUMMARY:

One in five adults in America experience a mental illness, yet despite this, greater than 60% of adults with mental illness did not receive mental health services in the previous year. In 2017, Merritt Hawkins, a national health care consulting firm, ranked psychiatry as the second most requested assignment for the second year in a row. Underscoring the developing crisis of access, a report released by the CDC in 2018 found that suicide rates rose across the US from 1999 to 2016, of which more than half did not have a known diagnosed mental health condition at time of death. The resulting burden of untreated mental illness can be seen through its effects on hospitalized patient's mortality, length of stay, and readmission rates. Furthermore, there is evidence suggesting that at least 20 to 40 percent of hospitalized patients have a mental health diagnosis, and that these patients in particular have prolonged hospitalizations. In attempts to combat the effects of this troubling shortage, many groups have worked to develop novel models of mental health care delivery. Through continued innovation and rigorous assessment of such models, health practitioners can continue to work to build partnerships to address the growing issue of access. We replicated one such proactive and integrative inpatient mental health care model to examine the effects on inpatient medical units. Our workshop will introduce the Behavioral Health Team implemented at Mount Sinai Hospital in New York City. We will highlight the differences between the Behavioral Health Team model and the traditional psychiatric consultation liaison model. Participants will be invited to take part in developing their own integrative approaches to two case examples that highlight particularly challenging patients with comorbid psychiatric needs. We will review the impact of the Behavioral Health Team on various metrics and collaborator satisfaction surveys, and invite feedback on potential ways to demonstrate objective efficacy of such programs in the future. In addition, we will provide an interactive opportunity to query invited collaborators from medicine on their experiences with proactive mental health programs.

Peer Support and Community Psychiatry: At the Intersection of Public Health and the Politics of Self-Determination

Presenter: Justin Barron

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the background and grounding principles of peer practice; 2) Identify the points of tension arising between peer support models of health and psychiatric models of health.; and 3) Understand key institutional changes that can be implemented to incorporate peer workers in substantial and meaningful ways..

SUMMARY:

This presentation will present an overview of conceptual, theoretical, and political foundations of peer practice with a special view to how peer support models interface with the field of community psychiatry. The primary aim of the presentation will be to illuminate a variety of shifts mental health institutions can take to incorporate a peer workforce in a meaningful and substantial manner, by bringing key points of tension into focus. The presentation will be composed of two main sections. The first section will introduce peer support as a practice that provides community psychiatry an opportunity to critically consider how matters of mental health are always at least as much a matter of politics as biology. Peer support work promotes the individual whom services are meant to assist and impact as the primary stakeholder, requiring a reconfiguration of the hierarchy of relations implied in institutional medicalized practice. Peer support work indicates that how we think about appropriateness of care, intervention, and treatment reflects a commitment to a social ethic as much as a professional medical one. The presenters will explore the imperative that community psychiatry not lose track of this social/ethical commitment when considering how peer workers might best be integrated into services. Even with the tensions and debates around decision-making capacity, "insight", and "risk", expanding access should not be conflated with "mandates" to care. Peers can contribute to the conversation around what it means to expand "access" that sometimes serves to re-code coercion

as choice. The second section will comprise an exploration of how the field of community psychiatry can change to incorporate peer work in meaningful ways, focusing on improved access to care. Included in this section would be discussions on workplace structural changes, and discussions on defining “lived experience” and its relevance in a variety of support roles. Meaningful and purposeful integration of peer support roles does not mean that differences have to be reconciled or resolved, but they must be held in the forefront and be part of any effort to incorporate peer work into the system. Without a commitment to this, peer-oriented practice risks becoming rhetoric and nothing more.

Psychiatrist Burnout: Cutting-Edge and Evidence-Based Understanding and Intervention

Chair: Sheila M. LoboPrabhu, M.D.

Presenters: Richard F. Summers, M.D., H. Steven Moffic, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the three main symptoms of burnout as described in the Maslach Burnout Inventory.; 2) Define physician impairment and describe how burnout can progress to impairment; 3) Explain the role of the electronic health record in affecting physician burnout; and 4) Identify at least one online tool available to measure and self-monitor psychiatrist burnout..

SUMMARY:

Burnout levels have now reached 54.4% across the United States. Legislative changes, the recent recession, and changes made by insurance companies, employers and public health care providers have all contributed to increased burnout. Nearly two-thirds of U.S. physicians report feeling burned out, depressed or both, according to the Medscape National Physician Burnout and Depression Report 2018 surveying 15,543 practicing physicians. In addition, respondents stated these depressive feelings impact their relationships with patients and therefore patient care. Physicians’ burnout rates range from 23-48% by specialty and psychiatrists report a burnout rate of 36-74%. Only 41% of physicians feel that work leaves enough time for personal or family life. In this workshop, we aim

to educate psychiatrists about the key concepts of stress, burnout and physician impairment. The workshop will start by defining these terms and discussing causes and effects of these conditions on healthcare in the United States, particularly on mental health care provided by psychiatrists. It will discuss how excessive productivity quotas and limitations on time spent with patients (such as the electronic health record, shorter visits) are major sources of psychiatrist dissatisfaction. It will discuss unintended consequences of legislation which aims to provide cost-effective healthcare to every American. It will discuss rules, regulations, and compliance measurement becoming overwhelming to psychiatrists by taking time and resources away from patient care. It will go on to discuss new knowledge and recommendations about burnout in psychiatrists, with additional focus on burnout in medical students and residents, and physician suicide. The final part of the workshop will discuss interventions to address and prevent burnout with emphasis on the work of the American Psychiatric Association (APA) Workgroup on Psychiatrist Burnout. It will introduce psychiatrists to tools available to self-monitor burnout on the APA website. We will discuss cutting-edge information that we learned while editing the new American Psychiatric Publishing Inc. book on combating burnout in psychiatrists.

The 2019 ACGME Common Program Requirement on Diversity and Inclusion: How Training Programs Can Innovate and Collaborate to Improve Access to Care

Chair: Francis G. Lu, M.D.

Presenters: Jessica Graham Kovach, M.D., Iverson Charles Bell, M.D., Ulrick Vieux, D.O., Myo Thwin Myint, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the meaning/significance of the new ACGME Common Program Requirement on diversity/inclusion, an accreditation standard for all residencies/fellowships of all specialties effective 7/1/2019; 2) Describe the relationship between a diverse and inclusive workforce and access to care for underserved populations.; and 3) Describe specific action steps

residency/fellowship programs can take in their own depts. of psychiatry towards meeting this new accreditation standard with a focus on recruitment of trainees/faculty.

SUMMARY:

This workshop will first describe the meaning/significance including access to care for underserved populations of the 2019 ACGME Common Program Requirement (CPR) on diversity/inclusion, an accreditation standard for all residencies/fellowships of all specialties effective 7/1/2019: "I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community." Until now, ACGME has not had a diversity/inclusion accreditation standard, which closes the gap between the 2009 LCME accreditation standard on diversity/inclusion for U.S./Canadian medical schools and the ACGME accreditation standards for all residencies/fellowship programs of all specialties in the U.S. Both the LCME accreditation standard and the new ACGME CPR advance diversity/inclusion as a driver for health equity/disparities reduction (Nivet, 2011). Secondly, the workshop presenters will outline a checklist of concrete specific action steps that residency and fellowship programs can take towards meeting this new accreditation standard: 1) Partner/align with the Sponsoring Institution's "policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims." by working with the Designated Institutional Officer overseeing GME, Assistant/Associate Deans of Diversity, AAMC Group on Diversity and Inclusion/Group for Women in Medicine and Science designated representatives, Chief Diversity Officer. 2) Work with Department of Psychiatry leadership to establish a Department of Psychiatry Diversity Advisory Committee charged with developing a strategic plan for implementing policies and procedures of recruitment and retention for trainees, faculty and staff. 3) Work closely with all psychiatry GME training programs to ensure

compliance with the mandated annual evaluation of the assessment of the program's efforts to recruit and retain a diverse workforce including holistic review of applicants modeled after the AAMC guidelines for medical student applicants. 4) Work with faculty search committees in implementing policies of recruitment of a diverse and inclusive workforce as modeled by the University of California that do not discriminate on the basis of race/ethnicity and gender. Finally, the workshop will engage the participants in two focused small group discussions: 1) to identify opportunities, challenges, and resources for strategic plan development in their home programs, 2) how participants can implement holistic review of applicants and faculty search guidelines at participants' home programs.

Update on Mental Health Issues in LGBTQ Youth

Chair: Kenneth Bryan Ashley, M.D.

Presenters: Gabrielle L. Shapiro, M.D., Timothy C. Van Deusen, M.D., Jose Luis Aguilar, M.D., Ali Maher Haidar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about cyberbullying of LGBTQ youth and suicide prevention in the digital age.; 2) Illustrate the possible role of the internet in transgender development and the associated challenges for clinical management.; 3) Review current guidelines and recommendations for treating transgender youth.; and 4) Appreciate specific considerations to be taken into account when treating displaced LGBTQ youth..

SUMMARY:

This workshop will update various topics dealing with lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. Dr. Shapiro will speak on the issue of cyberbullying which is rampant internationally in adolescents. The consequences of cyberbullying to children and adolescents will be discussed, including its link to depression and suicide in LGBTQ youth. The use of social media as a tool for information and connection in LGBTQ youth will be discussed as well as concerns with cyberbullying and use of the media as 'a cry for help' when suicidal. Ways to assist parents, clinicians and school personnel in identifying victims of cyberbullying will be discussed

as will educational tools to combat cyberbullying in our communities. A clinical vignette will be presented, and an open discussion with audience participation will follow. Dr. Van Deusen will present a psychiatric case report of L, a 20 years old transwoman who claims she saw "JS", a transwoman performer, on YouTube at the age of 10 and that they have been "together" since that time. This case illustrates the possible role of the internet in transgender development and the associated challenges for clinical management. It also describes retrospectively the childhood and adolescent development of a patient whose transgender development involves the internet in the context of a complex psychiatric condition. Dr. Aguilar will review current guidelines for treating transgender youth and present published data on the psychological outcomes of puberty suppression treatment. An increasing number of transgender youths are seeking gender-affirming medical and surgical interventions, but there is a paucity of evidence informing many of the current treatment guidelines. Puberty suppression treatments allow transgender adolescents to experience puberty in their identified gender. Unfortunately, many physicians are inexperienced or uncomfortable treating transgender patients, and some outright refuse care. The high prevalence of depression, anxiety, trauma, self-harm, suicide, and substance use disorders in transgender youth support the need for awareness, advocacy, and a multidisciplinary approach to caring for this marginalized and underserved population." Dr. Haidar will discuss the emerging struggles faced by LGBTQ youth who find themselves homeless. The talk will explore the reasons for and outcomes of LGBTQ individuals' homelessness in comparison with the general population. The presentation will include didactic material from studies exploring the issue as well as clinical material from the case of a young LGBTQ patient faced with homelessness in an urban area.

Learning Labs

Thursday, October 03, 2019

Child or Adult? Navigating Collaborative Treatment of Transitional-Age Patients

Chair: Steven N. Adelsheim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand supplementary resources available within secondary schools and colleges.; 2) Assess school administration's involvement in patient care.; and 3) Formulate collaborative care plans within the patient's support network..

SUMMARY:

Caring for transitional-age patients can be tricky. Finding the correct resources within secondary schools and higher-education is confusing and causes delays in care. Utilizing systems of care principles, this session will role play vignettes and problem solve common issues.

Friday, October 04, 2019

Intern Year—The Board Game: An Educational Experience for Learning About Physician Wellness, Burnout, and Depression

Presenter: David A. Ross, M.D., Ph.D.

Co-Authors: Joseph J. Cooper, M.D., Melissa Arbuckle, M.D., Ph.D., Manesh M. Gopaldas, Andrew Novick, M.D., Ph.D., Elise Stephenson Scott, Desiree Nicolette Shapiro, M.D., Maja Skikic, M.D., Michael John Travis, M.D., Ashley E. Walker

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.

Saturday, October 05, 2019

Leveraging Intergenerational Differences and Strengths: Leadership Development, Education, and Patient Care

Chair: Jacqueline M. Feldman, M.D.

Presenters: Francis G. Lu, M.D., Mary Kay Smith, M.D., Lee Feldman, Anna Davies

Discussant: Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVES:and

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

SUMMARY:

Comparing intergenerational differences between Millennials and Baby Boomer provokes considerable discussion and affect. Millennials experienced the economic uncertainty from the 2007 financial crisis, which led to 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 differences and 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.

Medical History Mystery Lab

Chair: Kenneth Bryan Ashley, M.D.

Presenters: Daniel Safin, M.D., Carmen Casasnovas, M.D.

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 collaboratively 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 play 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.

Media Sessions

Friday, October 04, 2019

Conversion Therapy: *Boy Erased*, Can It Alter Sexual Orientation Without Causing Harm?

Chairs: Jose P. Vito, M.D., Amir K. Ahuja, M.D.
Presenters: Garrard Conley, Daniel S. Safin, M.D., Shervin Shadianloo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to understand the constitutionality of legal prohibitions of sexual conversion therapy; 2) At the conclusion of this session, the participant will be able to learn what does conversion therapy do.; and 3) The participants will demonstrate what it's like to experience gay conversion therapy..

SUMMARY:

Conversion therapy, also known as “reparative” therapy, refers to the practice of “curing” LGBTQ identities. While the method varies from prayer to talk therapy, it usually involves violence and humiliation. Though the practice has been

discredited by the nation’s leading mental-health organizations, it’s still legal in 41 states and an estimated 20,000 LGBTQ youth ages 13 to 17 will undergo conversion therapy with a licensed health-care professional before the age of 18

Only Connect: The Enduring Legacy of EM Forster’s *Howard’s End*

Chair: Howard Charles Rubin, M.D.
Presenter: Robert Michael Kertzner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To introduce the audience to the novel *Howard’s End* and show the film version.; 2) To explore how themes of stigma, class and gender inform our appreciation of the film and novel.; and 3) To teach the audience how analyze a work of art through the lens of their psychiatric experience..

SUMMARY:

Howard’s End by EM Forster is one of the most important British novels of the Twentieth Century and one that many writers have used as a touchstone for their own work. What is it about the story that is so enduring and powerful? What elements in the story resonate for us as psychiatrists? This presentation will employ a screening and discussion of the 1992 Merchant Ivory film version of the novel to explore how stigma and the constraints of class, socioeconomic status, and gender affect the choices the characters make. We will discuss the price the characters pay for the transgressing those roles. We will use Forster’s phrase, “only connect” to explicate the challenges his characters face in communicating their needs, expectations and desires. Finally, we will introduce the idea of “inheritance” as a metaphor for cultural transmission of values/wisdom /empathy. We are presenting this film in conjunction with the Broadway premiere and current production of an important new American play entitled *The Inheritance* by Matthew Lopez, which might be described as *Howard’s End* meets *Angels In America*. The play uses and updates the broad outlines of the Forster novel to portray the lives and loves of a group of gay men living in contemporary New York. Conference participants will have the opportunity to

see Part One of The Inheritance on their own, fortified by our discussion and screening of *Howard's End*.

Saturday, October 05, 2019

Blindspotting: The Power of Social Determinants and Our Remarkable Ability to Miss Their Effects

Chair: David Louis Beckmann, M.D., M.P.H.

Presenters: Adrienne Taylor Gerken, M.D., Lucy Ogbu-Nwobodo, M.D., M.S., E. Cabrina Campbell, M.D., Derri Lynn Shtasel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize ways in which social determinants such as race, neighborhood, and legal involvement can have profound and under-recognized impacts on the lives of individuals and communities; 2) Explore ways in which the “blind spots” of providers (and society) magnify the disadvantages of marginalized groups; and 3) Discuss how art and media can be used with learners (including psychiatry residents) to overcome blind spots regarding the impact of social determinants, particularly race.

SUMMARY:

Real-life best friends Daveed Diggs (actor and musician of Hamilton fame) and Rafael Casal (a spoken word poet) wrote and starred in the critically acclaimed 2018 film *Blindspotting*. Collin (Diggs) is a black man on his last three days of parole who is trying to do the right thing despite the antics of his best friend Miles (Casal), who is white, has no criminal record, and feels he has something to prove in a rapidly gentrifying Oakland. But when Collin witnesses the unprovoked shooting of a black man by a white police officer, the trauma of the incident threatens to derail his success. Race, class, and the implications of a legal history are all explored in this comedic drama, which uses levity, poetry, and rap to always remain interesting and entertaining. The movie addresses ways in which these socioeconomic and structural factors influence the lives of millions of Americans—including our patients—and the ways in which society (and service providers such as psychiatrists) are complicit if they are not specifically attuned to these issues. Following the screening of

this 95-minute film, a panel of psychiatrists involved in public and community psychiatry and medical education will lead a discussion exploring how the themes addressed in the movie apply to patients throughout the United States, and ways in which providers can learn to recognize their blind spots. Attention will be paid to the role of art and media in medical education as a tool for teaching structural competency. Participants will receive a resource guide listing examples of relevant media and strategies for incorporating such resources into discussions or didactic sessions.

Poster Sessions

Thursday, October 03, 2019

Poster Session 1

No. 1

Adult Community Mental Health Education Toward Stigma Reduction in Underserved Communities: Barriers and Difficulties to Implementation

Poster Presenter: Maryssa Lyons

Co-Authors: George Matar, Neli Ragina

SUMMARY:

Background: In medically underserved Michigan, approximately 1,475,000 adult residents experience any mental illness (AMI), with approximately 57% not receiving treatment. Stigma is emerging as an important, community level, modifiable barrier to mental healthcare. Previous work on stigma reduction has revealed that educational interventions are the most efficacious in adult populations. Thus, we aim to determine the effect of education on mental health stigma among adults in mid-Michigan. **Significance:** The results of this study assist in characterizing the effects of mental health education on stigma in the community and display the transferable nature of educational interventions across settings and communities. We hope to increase the inclusivity of those with mental illness through education. **Methodology:** Events are held in collaboration with local organizations of community involvement. The presented data represents a pilot study. Knowledge and attitudes towards mental health will be assessed by an anonymous confidential pre-survey, followed by an educational

intervention and post survey. Both surveys use portions of a validated survey published in the Attitudes to Mental Illness 2014 Research Report. The surveys identify demographics and current perceptions and knowledge of mental health before and after the educational intervention. Educational Intervention is given by medical students with mental health specific training and consists of a 45-minute presentation based on the 8-hour Mental Health First Aid training with endorsement by local mental health professionals. Information is provided to participants about their local community mental health services and mental health support groups. In addition, an educational brochure regarding the presented educational information is given to all participants. **Results:** This pilot study enrolled 50 participants over 6 months. Enrollment consisted of small events of 2-20 people in community spaces, such as local coffee shops and places of worship. Preliminary analysis has shown decrease in multiple domains of stigma following education. **Conclusions:** Barriers to reaching the community have been study promotion. The most successful event took place at an investigators church, highlighting the need for community integration in this research. Despite barriers, preliminary analysis shows decreased levels in multiple domains of stigma following education. Implementation of full scale project will consist of 700 participants and focus on identifying stakeholders within organizations to better ensure event promotion.

No. 2

The Relationship Between Childhood Trauma and Adult Interpersonal Problems and the Role of Adult Attachment

Poster Presenter: Prerna Moorjani

SUMMARY:

Studies have shown that adverse childhood experiences (ACEs) can predict interpersonal difficulties in adulthood. The current study aimed to evaluate the association between childhood trauma and adult interpersonal distress and how attachment theory may help to explain this relationship. A sample of 257 patients recruited from the Albany Medical Center Outpatient Psychiatry Clinic completed a battery of self-report questionnaires during their admission to the clinic as part of routine

clinical care. The questionnaires included the Adverse Childhood Experiences (ACE; Felitti et al., 1998) – a 10 item scale that assesses for childhood abuse, neglect and household dysfunction, Experiences in Close Relationships (ECR-RS; Fraley et al., 2011) – a 12-item self-report instrument designed to assess adult related Attachment Anxiety and Attachment Avoidance in close relationships and the Inventory of Interpersonal Problems – Circumplex Scales Short Form (IIP-SC; Solz et al., 1995) – a 32-item scale that reflects the following 8 interpersonal problem styles: Dominant, Intrusive, Overly Nurturant, Exploitable, Submissive, Socially-Avoidant, Cold-Hearted, and Vindictive; a summary score reflecting general interpersonal distress can also be calculated. Results showed 56.6% of the patients (N = 257) had 4 or more ACEs. ACE Total ($r = 0.197$), ACE Neglect ($r = 0.203$) and ACE Abuse ($r = 0.217$) were all significantly ($p < 0.001$) correlated with higher general interpersonal distress. ACE Household Dysfunction ($r = 0.106$) was not significantly related to general interpersonal distress. Results suggest that both Attachment Anxiety and Attachment Avoidance are also correlated ($p < 0.05$; $p < 0.001$) with most types of interpersonal problems and general interpersonal distress. ACE Total and all subtypes other than Household Dysfunction were significantly correlated ($p < 0.001$) with Attachment Anxiety. Results suggested that Attachment Anxiety but not Attachment Avoidance mediated the relationship between ACE scores and general adult interpersonal distress indicating that ACEs may lead to attachment related fears of interpersonal rejection and abandonment which ultimately lead to current interpersonal problems. These results may help to inform clinicians on the importance of addressing attachment related issues associated with childhood trauma and current interpersonal problems.

No. 3

Effectiveness of the Hepatitis C Screening Protocol for the Psychiatric Inpatients at Pen Bay Medical Center

Poster Presenter: Harold W. Van Lonkhuyzen, M.D.

Co-Author: Hannah Olsen

SUMMARY:

BACKGROUND: Hepatitis C Virus (HCV) infection is a liver infection that typically begins as an acute infection and if left untreated, can become a chronic infection. Patients with mental illnesses are up to 9 times more likely than the general US population to be infected with HCV (Rifai, Gleason, & Sabouni, 2010). This study focuses on the effectiveness of an established universal HCV screening protocol utilized at the Psychiatric and Addiction Recovery Center (PARC) at Pen Bay Medical Center (PBMC), evaluating the rate of screening, diagnosis, and follow-up care of HCV. **METHODS:** A retrospective chart review was conducted to collect patient information on HCV screening during admission, whether they were diagnosed with HCV, and if there was evidence of HCV follow-up care. The chart review was conducted comparing patients' electronic medical record (EMR) before and after the implementation of the screening protocol established in January 2017. **RESULTS:** There were 613 patients admitted to the PARC unit from October 1, 2014 to September 30, 2015 and 484 patients admitted to the PARC unit from July 1, 2017 to June 30, 2018. The results indicate a significantly higher percentage of patients being screened following the institution of the screening protocol (95%) as compared to patients screened prior to the institution of the screening protocol (30%) ($p < 0.0001$). Additionally, 55% of the HCV positive patients screened following the institution of the screening protocol received follow-up care, compared to 47% of the HCV positive patients screened prior the institution of the screening protocol. **CONCLUSION:** These findings suggest the success of the instituted universal screening protocol at the PBMC PARC unit and its importance in identifying at-risk patients and providing adequate treatment to those infected with HCV.

No. 4

Lamotrigine Overdose With Urine Toxicology Positive for Phencyclidine: A Case Report of Possible Cross-Reactivity

Poster Presenter: Jennifer Kraut, M.D.

Co-Author: Norma Dunn

SUMMARY:

Introduction: False-positives can occur when a medication has a cross-reactivity with the

immunoassay, often due to similarity in structure of the parent medication or one of its metabolites to the tested drug. The occurrence of false-positives is mostly affected by the type of immunoassay used and the particular agent being tested. We present a case of a 13 year old female who was status post overdose with lamotrigine with positive urine toxicology with PCP (Phencyclidine.) **Case Report:** Ms. A is a 13 year old female, with significant psychiatric history of Post-Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder. She denied any psychoactive substances of abuse including PCP. Her history was collaborated by her mother. History revealed that patient was found unresponsive in bed with a suicide note and bottles at her bedside with 13 of 100mg pills of lamotrigine missing and 13 of 50mg pills sertraline. She was brought to pediatric emergency room by ambulance activated by her mother. On arrival to the hospital, the patient was not verbally responsive; she was responsive only to tactile stimuli. Her vital signs were within normal limits. Her urine toxicology was positive for PCP. Her Basic Metabolic Panel, Liver Function Test, and Complete Blood Count were within normal. She was stabilized after two days and was transferred to child and adolescent psychiatry unit for continued treatment. She was treated with Zoloft 100mg daily, Seroquel 150mg daily, and Valproic Acid of 750mg po total daily dose (blood level 68.1 $\mu\text{g}/\text{mL}$) with good effects on her impulse control and mood lability. **Discussion:** The literature describes that lamotrigine can cause false positive urine toxicology for PCP. In Our case report, our patient denied any history of substance abuse and it was known that she overdosed on lamotrigine. Although a repeat urine toxicology was not done because of patient refusal to cooperate at that time, the suspicion that the positive urine toxicology for PCP was most likely from medication cross reactivity in a patient who has no clinical history of PCP use.

No. 5

Another Blind Spot: Intellectual Disability and Trauma in Severely Mentally Ill Outpatients, Results of a Cross-Sectional Screening

Poster Presenter: Berry Penterman

SUMMARY:

Background The association of Mild Intellectual Disability (MID) and Borderline Intellectual Functioning (BIF) with trauma and PTSD in severely mentally ill (SMI) patients is largely unknown. Studies in people with MID showed an increased risk for severe trauma, PTSD and other psychiatric disorders. Our study aims to investigate trauma and PTSD in both MID as well BIF in SMI outpatients treated in Functional Assertive Community Treatment (FACT) teams in the Netherlands.

Methods A cross-sectional study was performed in 5 FACT teams in two Mental Health Trusts in the Netherlands. The Screener for Intelligence and Learning disabilities (SCIL) and the Trauma Screening Questionnaire (TSQ) were used to screen for the presence of Mild Intellectual Disability (MID) and Borderline Intellectual Functioning (BIF) and trauma, respectively. Differences in outpatient compilation and scoring on these questionnaires were compared and tested by means of one side or two sided chi-square or when appropriate two sided t-tests. A post-hoc analysis was performed to investigate gender differences on MID/BIF or Trauma. Results A suspicion of MID and BIF as shown by the SCIL was identified in 40% of the patients. MID was identified in 20%. Lifetime trauma was reported in 86 %. A suspicion of PTSD was identified in 42% of the patients. Any kind of traumatic experiences occurred significantly more often in the SCIL positive (MID/BIF) patients. Neglect occurred most often in 57 % of the patients. Physical trauma occurred in 51% followed by sexual trauma in 44% and disaster in 38%. Especially the female MID/BIF patients experienced significant more sexual abuse than men, 61% against 23% in men. Conclusions In our study we found that 40% of an outpatient SMI population was screen-positive for MID/BIF. This group had significant higher rates on all kinds of trauma and on nearly all trauma symptoms. They also showed relatively more likelihood for PTSD. Sexual abuse occurred most often in the females.

No. 6

CHN Community Psychiatry Nurse Practitioner Fellowship: Innovation in Expansion of Provider Capacity

Poster Presenter: Katharine Frissora, D.N.P.

Co-Author: Gertie D. Quitangon, M.D.

SUMMARY:

Community Healthcare Network (CHN) is a not for profit organization with a network of twelve Federally Qualified Healthcare Centers (FQHC) in New York City delivering integrated physical and mental healthcare and innovative programs for low income, uninsured, underserved and special populations (HIV, LGBT, refugees, military families). CHN established the Community Psychiatry Nurse Practitioner Fellowship in response to the increasing demand for quality psychiatric services in the community. The role of psychiatric nurse practitioners is anticipated to continue to expand as the shortage of psychiatric physicians persists in the United States. Through the years psych NPs have been taking increasing clinical responsibilities in a variety of settings and prescriptive authority was added to their scope of practice in the 1980s. However the lack of standardization among academic programs leads to variability in training and proficiency upon entering into practice. There is concern among nurse practitioners as well as from other professionals who interact with nurse practitioners about how adequately prepared they are to work in public sector organizations. There is also an inevitable controversy in scope of training and practice of psychiatrists versus psychiatric nurse practitioners. The CHN Community Psychiatry Nurse Practitioner Fellowship transforms this controversy into a collaboration through post-graduate clinical and academic education with the primary goal of expanding the mental health workforce and increasing access to quality mental health care in the community. Current fellows and graduates of both Columbia and NYU Public Psychiatry Fellowships (PPF), as well as the former director of the Columbia PPF are involved in the development of the curriculum and the training and evaluation of the fellows. The fellowship further enhances clinical skills and prepares the psychiatric nurse practitioner to work in a systems based practice, increasing awareness of the larger context and system of healthcare through post-graduate clinical and academic education. In the full-time 12 month long program, the fellows have weekly didactics and case conferences and they hone their clinical skills as they provide direct patient care at CHN sites and on clinical rotations with community partners under the supervision of a senior psychiatric nurse practitioner

or psychiatrist. In 2017, the Institute of Community Living (ICL), a human services organization with specialized programs for patients with severe mental illness, partnered with CHN to launch an Integrated Care Psychiatric Nurse Practitioner Fellowship through grant funding. The ICL fellows provide patient care at ICL sites and join the CHN fellows for case conferences, didactics and clinical rotations. CHN is exploring a track for early career psych NPs from other community based organizations to join the weekly classes and case conferences.

No. 7

Houston Do We Have a Problem? Emergency Mental Health Calls to First Responders Following a Natural Disaster

Poster Presenter: John Saunders, M.D.

Co-Authors: Asim A. Shah, M.D., Joann Schulte, D.O., M.P.H., Sophia Banu, M.D., Jason Salemi, Ph.D., M.P.H., Deepa Dongarwar, M.S.

SUMMARY:

Project: This project leverages a collaboration between Houston city officials and community psychiatrists at Baylor College of Medicine to investigate mental health utilization after Hurricane Harvey. Our team recognized the dearth of analyses assessing mental health-related utilization following a natural disaster, despite the value in providing information to city planners and decision makers about services and community psychiatric services in the acute period following these events. To fill the void in knowledge, we are first exploring temporal changes in total mental health calls to first responding services of the Houston Police Department and Emergency Medical services (EMS) during calendar year 2017, and the extent to which changes may be associated with Harvey or its aftermath. The study is ongoing; however, project data will be available by October 2019. **Background:** Hurricane Harvey made landfall on August 25th, 2017 and over the course of the storm, it proceeded to dump nearly 52 inches, which was the largest amount for any single storm. In addition to sheer volume of water, the impact of the storm was reflected in the evacuation of 24 hospitals, the 780,000 people who evacuated their homes, and the more than 42,000 that were temporarily housed in shelters. Within Houston, two of the larger shelters

were the George R. Brown Convention Center (GRB) and NRG Stadium. It is estimated that, at one time during the storm, GRB had over 11,000 people for whom psychiatric services were established to address the mental health needs of those affected. In addition to psychiatrists and therapists, officers from the Houston Police Department (HPD) Mental Health division were at the shelters providing services. First responders – either police officers or EMS – are often the first contact for patients experiencing a psychiatric emergency. **Hypothesis:** We anticipated a significant increase in psychiatric calls to the Houston Police Department or to Emergency Mental Health in the acute period after Hurricane Harvey. We also hypothesized that there would be a significant change in the geospatial distribution of calls. **Methods:** All mental health calls to the HPD, reported daily during calendar year 2017, will be collected, including details on call status and disposition, as well as zip code-level data. EMS calls restricted to suicide, attempted suicide, or other specific mental health calls for the same period will also be obtained. Using zip codes, we will link these data to FEMA disaster areas within Harris County to better capture areas most impacted. The primary statistical methodology to analyze temporal changes in these outcomes will be the use of an interrupted time series analysis with segmented regression, which has been used effectively in the past to assess the impact of natural disasters on the immediate change in outcomes, as well as the longer-term changes in the temporal trends in those outcomes.

No. 8

Anticipating and Increasing Access to Mental Health Services in Pre- and Postoperative Weight Loss Surgery Patients

Poster Presenter: Geeta Santoshi Tadepalli, M.D.

Co-Author: Shambhavi Chandraiah, M.D.

SUMMARY:

Adult obesity rates have surpassed 30% in the United States, making Weight Loss Surgery (WLS) a growing reality in healthcare. Additionally, the growing cost of obesity and its medical sequelae including Type II DM, coronary artery disease, and obstructive sleep apnea as well as psychiatric comorbidity is currently over \$40 million per year. In

1991 the National Institutes of Health recommended multidisciplinary evaluation to include medical, surgical, psychiatric, and nutritional expertise. Eligibility criteria for WLS surgery include a BMI greater than 35 with obesity related co-morbidities or a BMI greater than 40 without co-morbidities. With increasing insurance coverage for WLS (to offset the projected cost of long-term obesity related diseases) a greater number of patients are opting for WLS. Current guidelines for pre-operative assessment include a thorough psychosocial evaluation that includes a clinical interview, evaluation of weight patterns, eating behaviors, and potential red flags for a complicated post-op course. However, this is not necessarily a uniform process conducted on all pre-op evaluations and often depends on the individual assessor. Primary behaviors such as binge eating, emotional eating, and loss of control eating as well as depression and anxiety disorders can occur in 40% of WLS candidates and need to be thoroughly assessed and addressed as they can greatly impact the post-operative course and outcome of WLS. Additionally, reports show increased incidence of post-op worsened depression, suicidal ideation, addiction, and emergence of underlying mental health problems that can also contribute to WLS failure rate. Post-operative care includes monitoring the need for changes in pharmacotherapy, nutritional needs, and emotional support. Given the multi-faceted nature of obesity, an individualized, stringent, and uniform pre-operative assessment and ongoing follow-up care from a multi-disciplinary team including but not limited to surgeons, psychiatrists, primary care providers, pharmacists, therapists, nutritionists, and physical therapists is critical to ensure optimal outcome from weight loss surgery. Case scenarios that illustrate access problems as well as new innovative and collaborative approaches to address this major problem will be discussed.

No. 9

Untreated Mental Illness and Substance Use Disorders Among Adults Seeking Public Legal Aid

Poster Presenter: Jack Tsai

SUMMARY:

There is growing attention on the intersection between mental health and legal systems. Most of this work has focused on the criminal justice system, and little is known about intersections between mental health and the civil court system. A total of 227 adults seeking public legal aid online in Connecticut, Maine, Massachusetts, and New Hampshire were assessed on their legal problems, mental health, and other psychosocial characteristics. The most common civil legal issues reported were related to debt, family law, and housing issues. Importantly, 83% of the sample screened positive for depression, 81% for generalized anxiety disorder, and 45% for drug use problems. However, only 34% reported past year mental health service use and only 17% reported past year substance abuse treatment. Many adults were experiencing multiple legal problems and regression analyses revealed that a greater number of legal problems was associated with greater mental health problems and lower self-efficacy and empowerment scores. Together, these findings suggest many adults seeking legal aid may also be experiencing untreated mental health problems which may exacerbate their legal situation. Civil legal settings may represent a new area for mental health screening and intervention.

No. 10

Future of Telepsychiatry With Mobile Technology

Poster Presenter: Mohd Aleem Khan, M.D., M.P.H.

Co-Author: Waseem Khan, M.D.

SUMMARY:

Mental illnesses have high prevalence in the United States. As per NIMH, nearly one in five U.S. adult lives with a mental illness. In the year 2016, 44.7 million adults were diagnosed with mental illness out of which 19.2 million (43.1%) received mental health treatment. More than half of the population with mental illness remains untreated. The recent opioid epidemic has exacerbated the crisis and underlines the need for more efficient and effective treatment options. As per CDC, in 2017 age-adjusted suicide rate is 14.0 per 100,000 individuals. On average, there are 129 suicides per day. Suicide and self-injury cost the US \$ 69 Billion annually. As per AMA, there is an acute shortage of psychiatrists in the U.S. Over 60% of U.S. counties do not have even

a single psychiatrist⁴ Recent advances in technology has increased access to psychiatry care in remote and underserved areas with the use of telepsychiatry. As per AMA, 27.8 percent of psychiatrists use telepsychiatry to treat their patients⁵ Psychiatry is behind radiology in the use of telemedicine. Psychiatry is way behind to Cardiology, Nephrology and Neurology in using remote patient monitoring. There are several reasons why patients do not seek psychiatry services. Social stigma, transport logistics, lower socioeconomic status of the patient leading to inability to expand resources needed for care, poor social support. Telepsychiatry via secured mobile application and remote patient monitoring using mobile gyroscope and sensors can resolve some of the above stated access and compliance issues. Remote Patient Monitoring is possible for all patients enrolled in the clinic and after they are discharged from the hospital. This can be accomplished through mobile application technology that enables sending questions to the mobile device used by the patient via push notifications. Every day the patient shall receive automatic questions with answers displayed in a multiple-choice fashion and this will give us a surveillance data that can be analyzed further to give a picture of the ongoing mental state of the patient. Patient will also get medication compliance reminders. Additional features can be incorporated that would alert the health care provider to any warning signs or red flags or dangerousness displayed by the patient and thus allow appropriate care to be administered in a timely manner. Constant feedback with remote monitoring could be helpful. It will be of great help especially in patients who are non compliant . It will also help to prevent disease relapse and lower suicide rates.

No. 11

Teletrain: A Pilot Program to Teach and Encourage the Innovative Use of Technology During Synchronous Telepsychiatry Visits

Poster Presenter: Monique E. Simpson, M.D.

Co-Author: Ali Nelson Canton, M.D.

SUMMARY:

Needs and objectives: There are limited resources that discuss innovative ways to use technology during virtual visits. We aimed to develop and

implement a resource for clinicians to use via the screen sharing feature. This allows clinicians to share content instantaneously with patients via the use of PowerPoint slides, highlighting content in real-time. In turn, patients may easily take this information home with them, for instance by taking a picture with their smartphones. Hopefully this will increase implementation and adoption of topics discussed during appointments. This has further benefit in engaging patients with more visual learning styles and during the process of informed consent. Effective use of this technology may also overcome barriers to care such as limited literacy and fluency by using visual aids and diagrams. Setting and participants: All telepsychiatry physicians were polled as to their current use of this feature and their interest in implementing this during synchronous clinic visits. There was overwhelming interest in this novel use of technology with less than half of current providers reporting knowledge of how to use this feature, and only 10% reporting current use of screen-sharing technology during visits. Description: We created a pilot resource for all telepsychiatry physicians to use based on feedback solicited during our quarterly conference call. We prioritized patient education in our pilot, making a universal slide set for our clinicians to use before, during or after appointments. Some of the topics included were: sleep hygiene, screen time basics for parents, non-medication strategies for improving attention, common side effects of stimulants, SSRIs and alpha agonists. The slide set was then shared both on the quarterly call as well as via e-mail with instructions on how to use the screen-sharing feature. Evaluation: Providers completed a pre-intervention survey and will be surveyed after this pilot project to assess their implementation of this technology and their perceptions of its utility and benefit in clinical settings. Providers will also be surveyed regarding patient response to using this technology during virtual visits. Analyses will additionally examine barriers to implementation for those clinicians who did not elect to use this resource. Discussion: These findings will have implications in future projects within the telepsychiatry department. If clinicians express a desire for the development of further resources, suggestions for additional topics will be gathered and used to guide future iterations. Future directions

also include surveying patients to assess their attitudes towards using technology in this manner during telehealth visits, their opinion on its utility and topics of interest for further use.

No. 12

WITHDRAWN

No. 13

Patient Satisfaction With and Use of Telemental Health Services in the Perinatal Period: A Survey Study

Poster Presenter: Marra Ackerman, M.D.

Co-Authors: Elizabeth Greenwald, Fayrisa Ilana Greenwald, M.D., Christina Ahn, M.D., Paraskevi Noulas, Ph.D.

SUMMARY:

Background: Pregnancy and the post-partum period are particularly vulnerable time periods for women during which mental health issues may emerge or worsen. The perinatal period often poses challenges for women in terms of access to healthcare, with barriers including transportation difficulties with a newborn, lack of support and/or childcare, and nursing constraints. Telemental health is a novel method of mental health care delivery, which has the potential to overcome some of these barriers and provide mental health services to women who might otherwise be prevented from receiving such care. This survey study assesses patient satisfaction with and ease of use of telemental health services in the perinatal period. Methods: We are conducting a cross-sectional survey study of female patients, between the ages of 18-50, who have participated in telemental health services at NYU Psychiatry Associates from March 2018 – May 2019, either during pregnancy and/or the first year post-partum. A one-time brief anonymous survey is administered via REDCap. The survey includes questions adapted from the Telehealth Usability Questionnaire (TUQ), developed to evaluate patient satisfaction with telemedicine. Results: From March 2018 – December 2018, 19 eligible participants have agreed to receive surveys. To date, we have received 10 completed surveys (10/19, 53% response rate). We plan to continue to enroll participants until May 2019. The following preliminary data is based on the 10 completed surveys. The majority of participants are

post-partum (7/10, 70%), Caucasian/white (9/10, 90%), and live at least 5 miles from NYU Psychiatry Associates (7/10,70%). Most use telemental health services for a combination of medication management and psychotherapy (7/10, 70%). Most participants agree (2/10, 20%) or strongly agree (5/10, 50%) that telemental health improves their access to healthcare services, strongly agree that telemental health saves them time traveling to a hospital or specialist (10/10, 100%), agree (2/10, 20%) or strongly agree (7/10%) that the system is easy to use and easy to learn, and agree (4/10, 40%) or strongly agree (5/10, 50%) that they are satisfied with telemental health services overall. Conclusion: Based on preliminary data, the majority of participants agree that telemental health in the perinatal period: improves access to healthcare services; is easy to use and to learn; and provides a satisfying means of accessing mental healthcare. These results may inform clinical practice and future studies of telemental health in the perinatal period.

No. 14

WITHDRAWN

No. 15

A Case Report of Late-Onset Catatonia

Poster Presenter: Jordan D. Taylor

Co-Authors: Badr Ratnakaran, M.B.B.S., Ralph Randolph McKenzie, D.O., M.S., Justin Bradley White, M.D.

SUMMARY:

Introduction: Catatonia is a neuropsychiatric syndrome characterized by motor, behavioral and autonomic signs. It is associated with psychiatric disorders, neurologic disorders, and general medical conditions. However, literature on the occurrence of catatonia in the elderly population is limited. Method: We present a case report of 68-year-old female with past history of major depressive disorder and chronic kidney disease, currently admitted due to a 1 year history of general deterioration of health along with decreased activity, decreased talk, decreased social interaction, decreased food and water intake, decrease in the past in taking care of self, word finding difficulties, urinary incontinence, possible auditory hallucinations, and persecutory delusions. On

examination patient is suspicious of staring, posturing, mutism, rigidity, negativism, immobility etc. suggestive of catatonic symptoms. Bush Francis catatonia rating scale score was 13/69. Results: Oral lorazepam 1 mg twice daily for catatonia along with oral fluoxetine 20 mg daily for depression was started. The dose of oral lorazepam was gradually increased to 1.5 mg BID. However any dose beyond this made the patient sedated on multiple attempts. Patient subsequently improved on the same dose following which lorazepam was gradually tapered and stopped. Patient continued to have depressive symptoms. Oral dextroamphetamine-amphetamine 5 mg daily was added for augmentation of antidepressants along with oral trazadone 50 mg and oral melatonin 3 mg QHS for insomnia. Patient's symptoms improved and was discharged on the 25th day. Bush Francis catatonia rating scale score on discharge was 4/69. We will also review available literature related to catatonia in the elderly . Conclusion: Catatonia can present in the elderly and treatment of cause along with benzodiazepenes remain the mainstay of treatment.

No. 16
Preventing Depression in Older Adults Using Video Chat: Longitudinal Data From a National Representative Sample

Poster Presenter: Alan R. Teo, M.D.

Co-Authors: Ladson Hinton, Sheila Markwardt

SUMMARY:

Background: Social isolation and depression are both common in older adults, which may be due in part to reduced opportunities for meeting up with friends and family. We aimed to examine whether use of certain types of online communication technology is associated with subsequent depressive symptoms. Methods: Data were obtained from the 2012 and 2014 waves of the Health and Retirement Study (HRS), a nationally representative, population-based prospective cohort. We examined associations between use of four online communication technologies (email, social networks, video chat, and online chat/instant messaging) in 2012 and depressive symptoms (eight-item Center for Epidemiologic Studies Depression scale) in 2014, with model adjustment for potential confounders. Results: Among 1,424 community-residing older

adults (mean age, 64.8), 564 (39.6%) did not use any online communication technologies, 314 (22.1%) used email only, and 255 (17.9%) used video chat (e.g., Skype). Compared to non-users (13.1%, 95% CI 9.5-16.7%) or those who used only email (14.3%, 95% CI 10.1-18.5%), users of video chat had approximately half the probability of depressive symptoms (6.9%, 95% CI 3.5-10.3%, $p=0.002$; 7.6%, 95% CI 3.6-11.6, $p=0.002$). Use of email, social media, and instant messaging were not associated with a lower risk of depression. Conclusion and Relevance: Use of online video chat technology such as Skype among older adults is associated with lower risk of depressive symptoms at two-year follow-up. Research investigating the feasibility, acceptability, and efficacy of Skype to increase older adults' opportunity for social contact and reduce depression is warranted.

No. 17
Leuprolide-Induced Low Testosterone in a Patient With Severe Recurrent Major Depressive Disorder: A Case Report and Literature Review

Poster Presenter: Jordan Lee Schwartzberg, D.O.

Co-Author: Arnabh Basu

SUMMARY:

Introduction: Leuprolide is a GnRH-agonist used in the treatment and prevention of prostate cancer that causes a decrease in testosterone, sometimes to barely detectable levels. Low circulating testosterone has been associated with depression, metabolic syndrome, as well as with increased risk of developing dementia. Objective: To describe leuprolide-induced low testosterone in a patient with severe major recurrent depressive disorder. Case: A 71 year-old male with only 1 previous episode of major depression in his youth, presented with severe treatment resistant depression following initiation of Leuprolide treatment for his prostate cancer. His symptoms were resistant to multiple medication trials and augmentation strategies, including Wellbutrin, Effexor and Aripiprazole, as well as ECT and TMS, with some improvement only after initiating Lithium and Nortryptiline. His testosterone levels were described as "undetectable" and his initial BDI was 30, improving to 19 shortly after treatment initiation. We believe the low testosterone level contributed to the

recurrence of his depressive episode, fitting temporally with symptom emergence, and that the severity and recurrence of his depression partially remitted only with an atypical medication regiment. Conclusion : Existing evidence points to an inverse relationship over time between depression and testosterone. Although testosterone treatment appears to be effective and efficacious in reducing depressive symptoms in men, currently there are no recommendations of starting testosterone treatment or what medication(s) are effective for these men. Further research is warranted to explore the possibilities of testosterone correction in older depressed males and the usefulness of early psychiatric intervention in those undergoing prostate cancer treatment.

No. 18

Navigation Through Cyberspace: Examining the Effects of Teens Venturing Into Social Media's Dark Side and Finding a Solution

Poster Presenter: Mahreen Raza, M.D.

Co-Author: Muhammad Faisal

SUMMARY:

Although the use of social media, such as Snapchat, WhatsApp, Instagram, VSCO and Reddit seems to be flourishing among the younger generations, there also seems to be a high correlation between the increase in social media use, low self esteem as well as insociability among them. Social media allows adolescents, as well as young adults, to finally have a voice which may have been repressed for most of their life- and has also allowed for movements such as #MeToo to start, which in turn increased the reporting of sexual assault. However, it also leads to: unnecessary stress; low body image; an obsession with their follower count; and unhealthy relationships. To start, social media requires you to put in a lot of personal information when making the account. This already puts you at risk because there may be catfishing predators out there looking for the right time to pounce at an innocent teen. Fortunately, this is alleviated as teens are finally getting enlightened of the risks of social media, which was very unlike 10 years ago. Moreover, it also attributes to low self esteem and low body image because social media helps define what society considers 'beautiful.' If you don't meet that

expectation, the rest of society will pressure you into doing so. This eventually leads to some developing body dysmorphia and a few eating disorders. Furthermore, social media also increases the risk of bullying, creating the worldwide phenomenon of 'cyberbullying,' as most bullies sit behind their screens, feeling much more powerful as a face to face confrontation isn't necessary. Our objective here is to emphasize and increase awareness of the effects that social media can have on a juvenile mind and the necessity of an increase in monitoring from the parents to ensure a smooth sail through their child's adolescence and their own life.

No. 19

Thyrotoxicosis and Bipolar Disorder: Manic Episodes Refractory to Thyroid Radioiodine Ablation

Poster Presenter: Priyanka S. Adapa, M.D.

Co-Author: Raymond Chiong, D.O.

SUMMARY:

Introduction: Mr. A. is a seventeen year old male, with no previous psychiatric or medical history, with daily tobacco and marijuana use. He originally presented to the emergency room, brought by his mother, with symptoms of mania including increased energy, multiple days without sleep, pressured speech, flight of ideas, and grandiose and delusional thought process. He had increased free triiodothyronine and thyroxine levels with essentially non-existent thyroid stimulating hormone levels. Ultrasound exhibited an enlarged thyroid gland with increased vascularity. He was started on propranolol five milligrams and methimazole twenty milligrams every twelve hours with no psychotropic medications. Within two days, his symptoms subsided. For five months, he maintained compliance with this regimen, with follow up until he stopped medications on an international trip. He rapidly decompensated and missed multiple flights back to the United States secondary to disorganized behavior. Ultimately, his mother brought him home. Upon arrival and immediate medical evaluation, it was concluded that his hyperthyroidism was most likely causing his manic symptoms. He underwent thyroid radioiodine ablation and began treatment for subsequent hypothyroidism. Five months later, he presented to our ED with symptoms of increased

energy, verbal and physical aggression (requiring multiple intramuscular injections), and grandiose delusions requiring admission. Fourteen days later, after complex multidisciplinary management between medicine, psychiatry and endocrine services, we restarted and adjusted his thyroid medication, as well as initiated valproic acid and clonazepam for manic symptoms. He stabilized and was discharged with appropriate follow up. This case highlights the difficulty clinicians have in distinguishing bipolar disorder in the context of multiple types of thyroid dysfunction and in the context of co-occurring chronic substance use. Methods: Multiple psychiatric and endocrine assessments over two years. Results: I assessed the psychiatric management issues when a patient presents with manic symptoms in the context of non-compliance with medical management of multiple types of thyroid dysfunction and marijuana induced symptoms of mania. After a review of literature, I have provided discussion regarding appropriately making the diagnosis of bipolar disorder in the context of an inconsistent medical comorbidity and chronic substance use. Conclusion: Patients require stabilization with medical and therapeutic management of thyroid dysfunction to rule out any medical causes of manic symptomatology before diagnosing bipolar disorder. Clinicians should also consider the likelihood of substance induced manic symptoms in a patient with chronic history of substance use. This case is a reminder of the importance of coordinated multidisciplinary approaches to medically complex patients with comorbidities that can mask and/or exacerbate their psychiatric illnesses.

No. 20

The Administration of Benzodiazepines in Deep Transcranial Magnetic Stimulation Increases Brain Tolerance in Resistant Depression Treatment

Poster Presenter: Jeronimo Saiz-Ruiz, M.D.

Co-Authors: Saiz Lola, M.D., Ph.D., Nestor Szerman, M.D., Fernando Sanjuan Martin, M.D.

SUMMARY:

Introduction Depression is related with the highest burden of disability worldwide. Some patients with major depressive disorder (MDD) have not responded adequately to pharmacological and

psychological treatment strategies for treatment-resistant depression. Deep transcranial magnetic brain stimulation (d-TMS) is increasingly being used in these cases (1), after the failure of protocol treatment. The most relevant adverse effect of this technique is the induction of an epileptic seizure. Epileptic seizures are often isolated and do not give rise to any kind of aftereffects or require further attention. The incidence is less than 0.1% (2, 3) and frequencies above 5 Hz increase seizure occurrence. In addition, antidepressants and antipsychotics drugs lower the threshold of cortical excitability and may contribute to the onset of seizures. Resistant Major Depression Disorder (MDD) patients were treated using the d-TMS with the H1 Brainsway coil, technique approved by the EMA and the FDA (4). The H1 coil activates cortical and subcortical regions of left predominance. The evolution of depressive symptoms was assessed with the Hamilton Depression Rating Scale. Results We report a case of a 33-year-old Caucasian male with resistant MDD (DSM-5) treated for more than ten years. Despite multiple antidepressant drug trials and psychotherapy the patient does not respond to these treatments and his quality of life was significantly impaired. During the last two years, we have been treating him with d-TMS and the result was a strong improvement in depressive symptoms, mood, general health, and overall functioning. However, the patient experienced in a maintenance session a generalized tonic-clonic seizure. The EEGs ruled out epileptiform anomalies. Administration of 25 mg of diazepam prior to treatment (15 mg last night intramuscularly and 10 mg orally one hour before) allowed three new sessions without any other adverse effect. Conclusions: Benzodiazepine use in deep TMS may be useful in order to continue the treatment in patients who have presented epileptic seizures without the presence of epileptogenic activity in a prolonged EEG.

No. 21

WITHDRAWN

No. 22

Bipolar and Related Disorder Due to Another Medical Condition: A Case of Mania in the Setting of Glioblastoma Multiforme

Poster Presenter: Xavier Yang Diao, M.D.

Co-Authors: Xiteng Yan, Omar Mirza, D.O.

SUMMARY:

Mr. A is a 55-year-old male with no prior medical, psychiatric, or family history who was initially admitted to an outside hospital for a left femoral neck fracture after a mechanical fall on a subway track. While on the orthopedics floor, he began exhibiting hypersexuality and pica, for which the psychiatric consult-liaison service recommended a noncontrast computed tomography (CT) of the head. CT revealed a complex mass in his right temporal lobe with subfalcine and uncal herniations that was redemonstrated on contrast-enhanced magnetic resonance imaging, showing a multiloculated mass with surrounding edema and midline shift. Thereafter, the patient was transferred to our institution for neurosurgical resection of this mass with tissue evidence of glioblastoma with focal sarcomatous components on pathology. On intake interview by our consult service, the patient was floridly manic, pressured in speech, markedly irritable, disorganized in behavior, and endorsing grandiose delusions of immense wealth and having a celebrity following. Per corroborative obtained from multiple collateral informants, his presentation was diametrically opposite to his baseline, which they described as "wise, "calm," and "never losing control." Collateral information revealed a 1-month history of personality disturbances, decreased sleep, "talking fast and in circles," bizarre behavior at work, and increases in goal-oriented activities. The patient was initially started on levetiracetam for postoperative seizure prophylaxis and dexamethasone for cerebral edema by the primary team, the former which was switched to valproic acid by our team and the latter tapered. We had also recommended standing and as-needed olanzapine for psychotic mania and breakthrough agitation, respectively. He was subsequently transferred from the neurosurgery service to our inpatient psychiatry unit for further management of his mania and psychosis after medical clearance. There, he was maintained on valproic acid (up-titrated to therapeutic serum levels), as well as olanzapine. He was ultimately discharged with attenuation of affect and maintenance of behavioral control. Mania in the setting of space-occupying lesions is an uncommon phenomenon and sometimes associated with right

frontotemporal tumors in case series and observational reports (1). The pathophysiologic underpinnings of such processes are unclear, but may represent convergences with nonorganic bipolar illness in terms of shared neurocircuitries that involve the amygdala, dorsolateral prefrontal cortex, and temporal lobes (2).

No. 23

Cannabinoid Hyperemesis Syndrome Masquerading as a Schizophrenia Spectrum Disorder

Poster Presenter: Earth Hasassri, M.D.

Co-Author: Keith Wood, M.D.

SUMMARY:

Ms. C is a 27-year-old woman with a past psychiatric history of major depressive disorder, cannabis use disorder, and cyclical vomiting syndrome, who was brought to the psychiatric emergency room by her mother for abnormal behavior. On presentation she appeared internally preoccupied, partially mute, agitated, was banging head on the wall gently and tearfully, rolling around the floor as if swimming on the ground, slowly disrobed while slowly kicking the door, tossed over the mattress in her room on the floor and then laid down next to it. Ms. C reported having a common cold about two weeks prior followed by a feeling of malaise and depression. This illness caused her to feel increased stress related to her employment and led her to smoke more cannabis than usual such that she would spend her entire waking hours intoxicated. For two days prior to presentation, Ms. C's mother was concerned that Ms. C was not able to work due to this change in behavior. She was admitted to the inpatient psychiatric unit for further clarification of symptoms with a preliminary diagnosis of schizophrenia based on one of the criteria for schizophrenia spectrum disorder: grossly disorganized or abnormal motor behavior causing problems in any form of goal-directed behavior, which can also be seen in other disorders such as cannabinoid hyperemesis syndrome. In this poster, we discuss the challenges and importance of differentiating between the disorganized motor behavior and psychotic symptoms arising from cannabinoid hyperemesis syndrome rather than a schizophrenia spectrum disorder.

No. 24**Pediatric Behavioral Health Urgent Care as an Alternative to the Emergency Room: Initial Findings**

Poster Presenter: George L. Alvarado, M.D.

Co-Author: Vera Feuer

SUMMARY:

Background: Pediatric behavioral health crises are a growing source of referrals to the emergency room, a large portion of which are preventable. This problem is largely driven by lack of timely access to mental health services, particularly child psychiatry. With some notable exceptions, emergency department (ED) evaluations can be suboptimal, focused on disposition but with limited attention to aftercare. Additionally the ED environment can often be stressful and stigmatizing, further complicating treatment engagement post-discharge. The Behavioral Health (BH) Urgent Care has arisen as a promising model with the potential to fill the service gap left by traditional outpatient and acute care services. Objective: 1. Describe the clinical and demographic trends of youth referred for Urgent Evaluation 2. Examine effect of the service on emergency room utilization and inpatient admissions Design/Method: The BH Urgent Care Service was established in the Spring of 2017. Located in an ambulatory setting near the ED, services are available weekdays from 10AM-2:30 PM for walk in evaluation. Referral is open to the community and criteria is restricted to subacute crisis absent a recent suicide attempt, agitation, intoxication, or the need for immediate medical attention. Patients requiring a higher level of care are escorted to the ED, so that there is no "wrong door." Assessment includes meeting with a child psychiatrist, coordination with external collaterals, and connection to outpatient care post discharge. Medication can be initiated, and patients can be seen for follow up bridging visits if needed. Results: In the first 20 months the service has seen over 1600 patients. This helped decrease ED volume by about 11% and helped decrease inpatient admissions by about 10%. 96% of patients were treated and released, while over 60% received enhanced referrals to outpatient care. Patient surveys were collected at the end of each visit and have shown a 98% satisfaction rate with the services received. Linkage rate to our on-site outpatient mental health

clinic was nearly 90%. Conclusion: The BH Urgent Care expands specialty access for youth in crisis and reduces preventable ED utilization. It also provides a transitional care space and helps close the service gap that exists in crisis care, particularly for psychopharmacology. Feedback from patient and community stakeholders (schools and primary care providers) has been uniformly positive, with the exception of limited service hours. Service sustainability has been aided by continued volume growth, as well as by the strategy of economizing psychiatric resources between the ED and urgent care service.

Friday, October 04, 2019

Poster Session 2**No. 1****An Unintended Consequence of Treatment Authorization Request Regulation for Antipsychotic Use in Californians Under 18 on Medicaid: A Case Study**

Poster Presenter: Samuel Robert Murray, M.D.

Co-Author: Paula Wadell, M.D.

SUMMARY:

As of October 1, 2014 California State Law requires an approved Treatment Authorization Request (TAR) prior to dispensing antipsychotic medication to any person on Medicaid under the age of 18, regardless of diagnosis. Pharmacies are allowed to dispense a 72 hour supply of the medication while the TAR is being processed. The intent of the regulation is to address over use of antipsychotic medication in the foster care system. The topic became politically charged and the regulation passed without significant opposition. Case: Ms. L. is a 15 year old girl who presented to an early psychosis clinic for worsening perceptual disturbances. On interview she reported significant positive and negative symptoms of psychosis that had acutely worsened over the past 1-2 months as well as a significant decline in function over the past 2 years. She specifically endorsed command hallucinations to kill her-self and reported an interrupted suicide attempt a few months prior to the encounter. On exam she was timid and guarded, and notably paranoid, she was depressed with restricted affect. She was given

a diagnosis of Schizophrenia. At the time of the encounter she was on fluoxetine, which had been partially effective for mood and low dose quetiapine, which had not been effective for perceptual disturbances or for sleep. The treatment plan was to enroll her into services at the early psychosis clinic, to continue fluoxetine, to start aripiprazole and to discontinue quetiapine. The TAR process for aripiprazole was discussed with the patient and her family. Six days after the encounter, clinic staff received a call from the patient's stepmother asking for assistance in getting aripiprazole from the pharmacy. At that point, she had not received any aripiprazole and had been declined the allowable 72 hour supply by the pharmacy. Clinic staff placed multiple calls to the pharmacy, but was not able to get the pharmacy to agree to dispense the aripiprazole. Clinic staff reached out to the treating MD who was able to successfully advocate for a 72 hour supply of aripiprazole to be dispensed, though 7 days had passed since the original prescription. In that time, Ms. L experienced significant worsening of psychotic symptoms and distress. Discussion: There is a significant unintended consequence to the current TAR system; young people on Medicaid in California who are being prescribed antipsychotic medication for clinically indicated and FDA approved indications are experiencing delays in treatment that have potentially catastrophic outcomes. This poster will discuss the history of current TAR regulation in California, the unintended consequence it has had on patients at an early psychosis clinic, including preliminary data on medication delays and time spent by clinic staff. Importantly, the poster also discusses ongoing advocacy efforts to make reasonable policy changes to ensure adequate care to young people in California with psychotic illnesses.

No. 2

Acutely Induced Early Onset Schizophrenia in an Adolescent With ADHD

Poster Presenter: Alexandra Tibil

SUMMARY:

Case Report: A 16-year-old male with a six-year history of ADHD presented to the Emergency Department with altered mental status and bizarre behavior for one day. The patient had unintelligible

and nonsensical speech along with inappropriate disrobing and agitation. The patient denied auditory and visual hallucinations at that time. He remained in the psychiatric in-patient unit for seven days. The patient presented with acute onset of negative (eg, apathy, poverty of speech, latent response, flat affect) and positive (paranoia and response to internal stimuli) symptoms of schizophrenia while taking Vyvanse 60mg daily for ADHD. During his stay, Vyvanse was discontinued and he was given 0.5 mg of Risperdal BID and 10mg of Zyprexa PRN. Over the remainder of the hospital stay, the patient became more cooperative, able to follow commands, and able to complete activities of daily living with direction. He was discharged on day eight with a plan to follow up with his psychiatrist and psychologist for further evaluation and therapy. The patient was discharged with Risperdal 1mg BID and Vyvanse was discontinued. Upon follow-up with the patient over a six-month period, he had become withdrawn from his peers and family and had continued to have symptoms of paranoia. He also continued to respond to internal stimuli and at times exhibited aggressive behavior. The acute onset of hallucinations, paranoia, and negative symptoms with the use of Vyvanse and the improvement of symptoms when the Vyvanse was removed suggests that the stimulant medication played a role in the exacerbation of the psychotic symptoms observed in this case. **Discussion:** Children and adolescents with ADHD are 4.3 times more likely to develop schizophrenia as adults than individuals without ADHD (Dalsgaard). This fact indicates that practitioners should be aware of this association so that they are mindful of the proper treatment regimens that can be used if a co-morbid psychiatric condition arises with ADHD. The presented case above suggests that amphetamine use in adolescents with ADHD and early-onset schizophrenia can exacerbate symptoms of psychosis. Due to the atypical presentation of this case, it was difficult to immediately diagnose and treat the patient as the symptoms pointed towards an extensive differential. It was important to re-evaluate the patient at six weeks, three months, and six months following the primary acute psychotic episode in order to exclude certain diagnoses. **Conclusion:** The significant factors that must be noted in this case are the symptom variation with

and without the use of stimulant medication, the acute onset of symptoms and the lack of history of psychiatric disorders other than ADHD. These factors suggest that the stimulant medication contributed to the acute-onset of schizophrenic symptoms. We believe that further studies are needed to determine an algorithm for treating children and adolescents with less invasive methods prior to considering stimulant medication.

No. 3

Clinical Course and Need for More Comprehensive Management of a Schizoaffective Immigrant With Over Sixty-Five Hospitalizations and Poor Social Support

Poster Presenter: Jon L. Miller, B.A.

Co-Author: Nita V. Bhatt, M.D., M.P.H.

SUMMARY:

Ms. A. is a 59 year old somali female with an extensive history of Schizoaffective disorder, bipolar type with chronic right forearm swelling due to remote trauma who has presented to various psychiatric hospitals since first coming to the United States, totaling nearly 60 hospitalizations in Texas, and 6 hospitalizations (with lengths of stay of averaging 1.5 months each) since moving to Ohio in June of 2017. Patient has repeatedly been dropped off by her family near the community mental healthcare center for disorganized behavior, resulting in inpatient admissions. The family has at times also locked the patient out of the family house, leaving the patient to wander the streets. While seen as an inpatient, the patient was notably intrusive with staff and peers, found to be cheeking medications, inappropriately touching peers, and assaulted two nursing staff on initial day of evaluation while responding to internal stimuli. Though on a remote admission she had ocular gyruis crisis, patient was found to be behaviorally mimicking this on most recent admission and responded to long acting injectable medications without negative side effects and with great improvement. Per outpatient pharmacy, the patient had been non-compliant with her outpatient medications. Patient was previously set up with a community mental health agency and had been assigned a case manager, but followed up with neither. While most recently hospitalized, patient

was communicated with via live or phone Somali interpreter. She had forced medications approved and was administered Invega Sustenna 234 mg IM at 3 weeks. Patient previously responded well to long acting injectable medications and stabilized in the hospital. Patient was discharged into the care of her family who had previously allowed her to wander the street and at times locked her out of the family house. This case illustrates the challenges faced by the social and mental healthcare system when dealing with individuals who are not only dealing with serious mental illness, but also lacking any familial support. Could such cases be handled as elder abuse for slightly older patients, and how might the state mental health and justice system (in the case of abuse) more effectively treat such individuals and their families? Considering that the very high average cost of a mental health admission for Schizophrenia/Schizoaffective, our patient, with stays averaging 45 days, would be incurring great costs with multiple readmissions. In Texas, with 60 hospitalizations, and in Ohio with 6 hospitalizations, it is clear that great resources have gone into such patients as Ms. B. Such enormous resources going into a single individual highlight the gravity of the problem and cost to social and healthcare systems for such cases. Steps to better classify and prevent abuse of the mentally ill and more effective means of legally maintaining outpatient adherence to medications should be explored by the state and healthcare system.

No. 4

Challenges in the Management of Clozapine-Resistant Patients With Schizophrenia Spectrum Disorders

Poster Presenter: Asif M. Rahman, M.D.

Co-Authors: Wendy Rocio Martinez Araujo, M.D., Vamsi M. Chigurupati, D.O.

SUMMARY:

We present a case of a 54-year-old Caucasian male with past psychiatric history of schizoaffective disorder in partial remission, multiple inpatient psychiatric hospitalizations, 3 prior suicide attempts, and past medical history significant for hypertension, end-stage renal disease on hemodialysis, and atrial fibrillation, who presented to our facility from a nursing home following suicidal attempt by hanging.

Patient was observed exhibiting delusions that he had previously been demonically possessed and while in this state, he had sold his son's soul to the devil, for which patient has expressed unremitting feelings of guilt with suicidality. Trials of optimal dosages of olanzapine, quetiapine and lurasidone have failed to address the patient's psychotic symptoms. As a result, clozapine was initiated, with patient maintained on therapeutic dose, which was likewise ineffective at achieving robust response in symptoms. As a result, patient was referred for electroconvulsive therapy and long-term inpatient psychiatric hospitalization as the next steps in management. This case highlights the clinical challenges we face in our practice when dealing with treatment-resistant psychotic disorders.

No. 5

A Case of Clozapine-Induced Neutropenia: An Exception to the REMS Program Guidelines?

Poster Presenter: Ulziibat Shirendeb Person, M.D., Ph.D.

Co-Author: Michael Esang, MB.Ch.B., M.P.H.

SUMMARY:

Patients with clozapine-induced neutropenia have been shown to be at an increased risk of neutropenic recidivism when re-challenged (1, 2). We present the case of Mr. S., a 48-year-old African American male who was hospitalized for paranoid and somatic delusions in the setting of intermittent alcohol use. He had stopped taking clozapine prior to his hospitalization, on account of intolerable side effects. His absolute neutrophil count (ANC), on admission, was 1490/mm³. He was restarted on clozapine and, in three days, the ANC dropped to 800/mm³, so it had to be discontinued. He was subsequently tried on other antipsychotics to treat his psychotic illness, namely, olanzapine, risperidone, haloperidol, and aripiprazole. They were all, however, also associated with a drop in his ANC, and at one point, pancytopenia. The Hematology-Oncology service was consulted and it was recommended that all antipsychotic medications be held. Blood samples were drawn for a leukemia/lymphoma evaluation by the pathologist. Although, blood smear examination revealed atypical lymphocytes, the full complement leukemia/lymphoma evaluation revealed no

morphologic or immunophenotypic evidence of a lymphoproliferative disorder or increase in blasts. A brief interval of lithium therapy produced some leukocytosis with consequent improvement in the ANC. It was, however, discontinued to prevent a precipitous drop in the ANC as has been reported in the literature (1). In the absence of any antipsychotic treatment, his ANC continued to fluctuate between 970/mm³ and 1230/mm³. At the time of this writing, he is currently being evaluated for a possible course of electroconvulsive therapy (ECT). Mr. S's case highlights the need for increased vigilance when re-challenging previously neutropenic patients with clozapine. Although a differential diagnosis of his neutropenia could include an occult hematopoietic or acquired hematologic pathology, benign ethnic neutropenia (BEN) cannot be ruled out. According to the Clozapine Risk Evaluation and Mitigation Strategy (REMS) program (3), when a patient with BEN has an ANC of less than 500/mm³, clozapine can be continued as long as the benefits outweigh the risk of developing severe neutropenia. Our case, however, calls for caution when making this risk-benefit assessment, as re-challenging such patients can lead to precipitous drops in the ANC and a subsequent chronic state of neutropenia. A referral for ECT early in the patient's history may be more appropriate.

No. 6

Oral or Long-Acting Injectable Antipsychotics and Suicide Prevention Among People With Severe Schizophrenia

Poster Presenter: Sylvia Díaz

Co-Author: Juan J. Fernandez-Miranda

SUMMARY:

Background To prevent suicidal behavior among people with severe schizophrenia is an important treatment goal. And to improve adherence seems to be a way for reaching this outcome. The objectives of this study were to know treatment adherence and suicide attempts of patients with severe schizophrenia in a standard treatment in mental health units and under treatment in a community-based, intensive case managed program. And the role of oral or long-acting injectable antipsychotic medication on both outcomes. Methods Observational, mirror image study of ten years of

follow-up (treatment in an intensive case managed and community based program) and ten of standard treatment in mental health units, of patients with severe (Clinical Global Impression-Severity scale, CGI-S=>5) schizophrenia (N=344). Reasons for Program discharge (including deaths by suicide) and suicide attempts in both treatments were recorded. Also antipsychotic drugs used (1st vs 2nd generation and oral vs long acting injectable). Assessment included the CGI-S. Results After 10 years in the Program only 12.2% of the patients were voluntary discharges (In previous standard treatment: 84.3%). CGI-S at baseline was 5.9(0.7). After ten years 51.7% of patients continued under treatment (CGI-S= 3.9(0.9); $p < 0.01$); 19.3% were medical discharged (CGI-S=3.4(1.5); $p < 0.001$). Suicidal attempts decreased significantly compared to the previous ten years (38.9 vs 7.6% of patients; average 0.3 vs 0.07; $p < 0.0001$). Prior to begin in the Program, 61.1% of patients were treated with 2nd G antipsychotics and in the Program almost all of them, 98.4 % ($p < 0.00001$); and previously 72.4% of patients were on oral antipsychotics (OAP), and during the Program most of them changed to be treated with long-acting injectables (LAI): 56.7% ($p < 0.001$). In relation to suicide attempts, they were significantly related with being treated with OAP and not with LAI, both before treatment in the Program ($p < 0.001$) and especially during it ($p < 0.0001$). Conclusions The fact of being treated with long-acting injectable antipsychotics was clearly effective in improving treatment adherence and in reducing suicide attempts compared with oral ones in patients with severe schizophrenia both in standard treatment and in a case managed community-based program.

No. 7

Treatment With High Doses of Second Generation Long-Acting Antipsychotics for Patients With Severe Schizophrenia: A 36-Month Follow-Up

Poster Presenter: Juan J. Fernandez-Miranda

Co-Author: Sylvia Díaz

SUMMARY:

Background To evaluate treatment retention, effectiveness and tolerability of high doses of second-generation antipsychotic long-acting injectable (LAI) formulations in the treatment of

patients with severe (CGI-S of 5 and over) resistant schizophrenia. Method 36-Mont prospective, observational study of patients with severe schizophrenia who underwent treatment with 75 mg and over of risperidone long-acting injectable (RLAI) (N=60), 175 mg and over of monthly paliperidone palmitate (PP)(N=30) and 600 mg and over of aripiprazole once-monthly (AM)(N=10). Assessment included the CGI-S, the WHO-DAS and the Camberwell Assessment of Need (CAN) at the beginning and after 3, 12 and 36 months. And also laboratory tests, weight, adverse effects reported and reasons for treatment discontinuation. Hospital admissions in the previous 3 years and during the follow-up were recorded. Results The average doses were: RLAI= 111.2 (9.1) mg/14 days; PP = 228.7 (11.9) mg-eq/28 days; and AM =720 (110) mg/28 days. For all LAIs tolerability was good, decreasing side effects(SE) and biological parameters alterations compared with previous treatments, in special in AM group. There were no discharges due to SE with AM, one with PP and three with RLAI; and three with RLAI and one with PP due to lack of effectiveness. Weight and prolactin levels decrease, but not significantly except for AM. After 3 years, CGI-S, CAN and WHO-DAS decreased with all injectables ($p < 0.01$). There were significantly less hospital admissions than during the previous 36 months ($p < 0.001$), with no differences among injectables. Retention in treatment after 36 months was 90% with RLAI, 93.3% with PP and 100% with AM. Conclusions Tolerability of high doses of second generation long acting antipsychotics (in especial for PP and AM) was very good, being useful in improving treatment adherence in patients with severe resistant schizophrenia, and helping this way to get clinical stabilization and better functioning.

No. 8

Epidemiology of Schizophrenia in the Republic of Korea: A National Health Insurance Data-Based Study

Poster Presenter: JeeHoon Sohn

SUMMARY:

Background Although several community-based epidemiologic studies on mental health in Korea exist, the incidence and prevalence of schizophrenia and similar psychosis have not yet been addressed

with nation-wide data. **Methods** We used the Health Insurance Review and Assessment Service (HIRA) database, which includes nearly all Korean nationals. First, the number of people with primary diagnostic codes of psychosis, including schizophrenia, schizophreniform, and acute and transient psychotic disorders, between 2010 and 2015 were collected. The annual prevalence and incidence of schizophrenia and similar disorders (SSP) were calculated using the population data from the Korean Statistical Office. **Results** The 12-month prevalence of SSP and schizophrenia in the Republic of Korea between 2010 and 2015 were 0.48-0.66% and 0.40-0.52%, respectively; Their annual incidence rates between 2011 and 2015 were 118.8-148.7 and 77.6-88.5 per 100,000 person-year, respectively. Both the 12-month prevalence and the annual incidence were found to be increased every year. **Conclusion** The 12-month prevalence found in the present study was higher than that reported in community-based epidemiologic studies in South Korea; however, our results are similar to those from other countries. The annual incidence of SSP and schizophrenia was found to steadily increase and was higher than that of other countries. The high incidence rate observed in the current study needs to be studied further.

No. 9

Ankle Edema Induced by Olanzapine

Poster Presenter: Hassan Qureshi

Co-Authors: Danny G. Warda, Aditi Gupta, Parisa Biazar, Saeed Ahmed, M.D., Vamsi M. Chiguripati, D.O.

SUMMARY:

Antipsychotics have therapeutic benefits in a wide range of psychiatric disorders. Ankle edema is a rare complication that has been reported with a few members of this class. We present a case of a 46-year-old male with a past psychiatric history of Bipolar Disorder presented to the psychiatric emergency room with signs and symptoms of mania. The patient was found hyperverbal, pressured speech, endorsing the high level of energy, expressing grandiosity and easily distractible. After admission to the inpatient psychiatric unit, he was started on oral Olanzapine 5mg daily. Though he began to show improvement of manic symptoms,

however, on day three of his hospital stay, he developed bilateral ankle edema. The patient denied any past history of cardiac or renal diseases or any previous episodes of edema. The patient also denied any history of recent trauma to lower extremities or use of any concurrent medications. Patient had stable vital signs along with normal CBC, CMP and D-Dimers results. The x-ray showed diffuse soft tissue swelling of the bilateral lower extremities and minimal bilateral ankle joint effusion. With consultation of the medical team and excluding all conditions which may cause ankle edema, the culprit was found to be Olanzapine, evidenced by regression of edema completely upon discontinuation of it. A review of literature also supported our findings that Olanzapine rarely causes isolated ankle edema.

No. 10

Akathisia or Psychosis: A Case of How Difficult Determining Side Effect Versus Primary Psychosis Can Be

Poster Presenter: Jacob Wardyn, M.D.

Co-Author: Natalie Torres

SUMMARY:

Akathisia directly translates to an inability to sit and is commonly described as internal restlessness. However, it can be difficult to describe by patients, leading to either misdiagnosis or underdiagnosis and can be a cause of medication nonadherence. An example of this underappreciated complexity is with a patient presenting for a first episode psychosis who began to experience what was initially assessed to be increased paranoia after initiation of an antipsychotic. After further assessment it was determined that this paranoia was the patient subjectively reporting their internal uneasiness and believing something externally must be happening. The antipsychotic was a necessity and the patient was initiated on a short acting beta blocker. After this initiation, the patient's subjective paranoia dramatically decreased, reinforcing the clinical belief that this presentation was most consistent with akathisia. Therefore, in this poster we will discuss this case in further detail, discuss the complex and nuanced nature of primary psychosis and medication side effects, and discuss the akathisia's suspected etiology, symptomology, and possible treatments.

No. 11**Population Health Management Approach to Increase Utilization of Clozapine for Medicaid-Eligible Adults With Schizophrenia Spectrum Disorder**

Poster Presenter: Matthew O. Hurford, M.D.

Co-Authors: Richard Ross Silbert, M.D., Keith Ripley, L.P.C.

SUMMARY:

Background: Clozapine is the most effective antipsychotic for individuals with Schizophrenia Spectrum Disorder who do not respond to treatment with first or second-generation antipsychotics. Studies show that clozapine is associated with improvement in social functioning, occupational functioning and quality of life and that it may also reduce affective symptoms, hospitalization, secondary negative symptoms and tardive dyskinesia. However, side effects can present challenges which contribute to underutilization of this medication. Nationally, clozapine utilization has declined and is currently under 5%, but clinical efficacy and rates of treatment-resistant schizophrenia indicate expected utilization above 10%. In the present quality improvement effort, a behavioral health managed care organization (BHMCO) in Pennsylvania implemented provider education and a care management monitoring intervention to improve utilization of clozapine. Results presented are responses recorded in the electronic health record (EHR) around monitoring and clozapine rates over time. Method: A monitoring system was developed and implemented in the EHR to identify individuals with schizophrenia spectrum disorder, record information, and work with providers around clozapine prescribing. Information collected includes prior and current trial with clozapine and other antipsychotics, concurrent pharmacotherapy, and adverse reactions. Responses from the first 5 months of EHR implementation, June to October 2018, are presented for 1455 individuals with schizophrenia spectrum disorder. Clozapine utilization rates are derived from pharmacy data reported to the state and claims data from the BHMCO. Results: During the study period, 122 (8%) individuals were determined in the EHR as appropriate for a clozapine trial and 149 (10%)

reported prior or current utilization of clozapine. Of clozapine users, <2% reported stopping the medication due to an adverse reaction and 7% had current use of 2 or more antipsychotics. Most individuals identified (n=1306, 90%) had never taken clozapine. Of the non-users, 109 (8%) had experienced 2 or more unsuccessful trials with antipsychotics and 72 (6%) were considered appropriate for clozapine trial. Overall clozapine utilization rates within the BHMCO network for individuals with schizophrenia were 3.5% (564/16147) in 2016, 3.8% (617/16231) in 2017, and 4.0% (609/15228) in 2018 (Jan-Sep). The proportion of individuals with clozapine use in 2018 was significantly higher than in 2016, $z=2.3627$, $p=.01828$. Conclusion: Monitoring systems that utilize care managers to help facilitate clozapine prescribing can identify individuals for which a clozapine trial may be appropriate. These efforts when coupled with other educational and monitoring efforts may improve the appropriate use of clozapine.

No. 12**Treatment Refractory Delusional Disorder in a Forensic Psychiatric Patient**

Poster Presenter: Morgan Alexander

Co-Author: Nita V. Bhatt, M.D., M.P.H.

SUMMARY:

Ms. M is a 35-year-old admitted to a forensic psychiatric hospital for treatment of fixed grandiose and persecutory delusions after being charged with felonious assault against multiple police officers. Police involvement was initiated after the patient refused to pay a bar tab, claiming that she had "diplomatic immunity" and therefore did not have to pay. Her entire delusional framework was based on the discovery that she is the only biological child of Osama Bin Laden. She believed that the Russians were behind the 9/11 attacks and that Bin Laden was not, in fact, responsible. She also demonstrated Capgras delusions, stating that multiple family members had been replaced by members of the KGB and that she had been starved and tortured by them. Ms. M believes that she is being persecuted and kept at the hospital in spite of the diplomatic immunity and royal sovereignty she believes to be entitled to as Osama Bin Laden's daughter – she

perseverated on the notion that the Department of Homeland Security, the UN, and FBI Chicago were working to free her from her treatment team. The patient also endorsed depressed mood, severe anxiety, sleep disturbance, and panic attacks secondary to her delusional construct. Despite being floridly delusional, her thoughts were organized, associations were intact, affect was mood congruent, and she was intermittently cooperative with interviewers. After 4 months of inpatient treatment, Ms. M's symptoms remained refractory to SSRIs, typical antipsychotics, atypical antipsychotics, hydroxyzine, atomoxetine, benzodiazepines, buspirone and psychotherapy. Her delusions remained fixed and she continued to insist that her treatment team was committing high treason in their attempts to treat her. This case study represents the persistent and pervasive nature of delusional disorders and demonstrates the need for effective clinical practice guidelines in the treatment of delusional disorder.

No. 13

An Atypical Lifelong Parenteral Thiamine Regimen for Wernicke's Encephalopathy

Poster Presenter: Samra Shoaib

SUMMARY:

A 64-year-old male patient, with an extensive history of Alcohol Use Disorder (AUD) and a recent diagnosis of Major Depressive Disorder (MDD) with psychotic features and Wernicke's Encephalopathy with concomitant memory impairments, presented to the emergency room (ER) with progressive decompensation in walking, poor oral intake, diminished verbal communicativeness, and increased frequency of falls. After initial medical work up showing no pertinent findings except ventriculomegaly on MRI and treatment with IV thiamine and IV fluids, Consultation Liaison Psychiatry service was referred for cognitive disability and treatment of his mood. He was subsequently admitted to the inpatient Psychiatry service. On initiation of the recommended oral thiamine, he became abruptly delirious, combative and began self-injurious behavior. Abstinence from alcohol was instituted and a trial of a multi-drug regimen including donepezil, fluoxetine, risperidone, and lithium was undertaken without significant

improvement in mental status or behavior. The patient was started on an intravenous (IV) thiamine dose, followed by regular intramuscular (IM) dosing and he showed remarkable improvement within the ensuing 48 hours. Repeated attempts were made to reduce the IM burden on the patient and taper the intramuscular thiamine however he rapidly decompensated within hours of tapering the IM dose. Thus, this patient is being managed on a lifelong thiamine regimen administered three times daily and depends on it for cognition. This case was a clinical dilemma because the conventional treatment regimen for Wernicke's didn't bring about the desired outcome until the mode of thiamine administration and duration of treatment was exceptionally altered. This case illustrates the utility of a sustained intensive thiamine regimen irrespective of sobriety, as opposed to the traditional regimen of parental (primarily IV) thiamine for 3-7 days, followed by oral repletion until the patient achieves sustained abstinence. Conclusion: This is an unusual case of Wernicke's as the conventional treatment did not work, and the patient had to be given IM as an alternate route of thiamine. The longitudinal time-course of this case suggests a relationship between this route of administration and improvement, and indicates a potential life-long need for IM thiamine to maintain the patient's baseline cognitive status.

No. 14

A Systematic Review of Attitudes on Non-Psychiatrist Physicians to Consultation-Liaison Psychiatry

Poster Presenter: Balaji Subramanian Srinivasa Sekaran, M.B.B.S.

Co-Author: Badr Ratnakaran, M.B.B.S.

SUMMARY: Objective:-Consultation-Liaison Psychiatry has gained more acceptance in the past few decades with more medical centers providing services for the same. The aim of this study is to systematically review available literature on attitudes of non-psychiatrist physicians to consultation-liaison psychiatry. Methods: The authors undertook a systematic review by searching electronic databases. The keywords used were: physicians, general practitioner, attitudes, consultation- liaison psychiatry. Studies were

included in the review if they had been published in an English-language, peer-reviewed journal. Data extracted included aim, study design, sample size, response rate, year of the study, physician speciality, year of publications, country where the study was conducted and main findings. Results: The initial search identified 90 papers. After removing duplicates and assessing abstracts and full articles against the inclusion criteria, 10 articles were included in the review. All the studies identified were qualitative studies and were cross sectional in design. Overall, the attitudes were found to be negative. Doctors belonging to surgical specialties were found to have better attitudes than surgeons. Conclusion: As per the review, there is need for collaboration with non psychiatrist physicians for integrated/collaborative care of patients who have both psychiatric and medical illness. Education on consultation-liaison psychiatry of non psychiatric physicians will be needed for successful care of the same population.

No. 15
Suicidal Ideation Predicts Functioning and Quality of Life Over One Year After Acute Coronary Syndrome

Poster Presenter: Jae-Min Kim

SUMMARY: Objectives: This study aimed to investigate the associations of suicidal ideation (SI) evaluated within 2 weeks of an acute coronary syndrome (ACS) with functioning and quality of life (QOL) at a 1-year follow-up assessment. Methods: This study consecutively recruited 1152 patients within 2 weeks of a confirmed ACS episode; 828 of these patients were followed up 1 year later and comprised the study sample. SI was determined at baseline using the "suicidal thoughts" item of the Montgomery and Asberg Depression Rating Scale (MADRS-ST). At both examinations, social and occupational functioning was measured by the Social and Occupational Functioning Assessment Scale (SOFAS), disability was estimated by World Health Organization Disability Assessment Schedule-12 (WHODAS-12), and QOL was assessed using the World Health Organization Quality of Life-Abbreviated form (WHOQOL-BREF). Baseline covariates included sociodemographic data, depression characteristics, cardiovascular risk

factors, and current cardiac status. Results: SI at baseline was independently associated with less improvement or worsening in the scores on SOFAS, WHODAS-12, and WHOQOL-BREF over 1-year after adjusting for relevant covariates. Conclusions: SI within 2 weeks of an ACS episode predicted poorer functioning and QOL outcomes at a 1-year follow-up assessment. Thus, the simple evaluation of SI in patients with recently developed ACS could be helpful in screening for functioning and QOL during the chronic phase of this disease.

No. 16
The Role of Quetiapine in Protection of Neurogenesis After Traumatic Brain Injury

Poster Presenter: Joseph A. Morra

Co-Author: Adekola Alao

SUMMARY:

Schizophrenia is a chronic psychotic disorder in which patients experience both positive and negative symptoms for a period of over 6 months. Positive symptoms include hallucinations, delusions, and disorganized speech and/or behavior. Negative symptoms include anhedonia, social isolation, flat affect, and alogia. Schizophrenia is also associated with early mortality, with 40% of this excess mortality due to suicide (Hor & Taylor, 2010). This is a case of a patient with schizophrenia who was placed on quetiapine after suffering a traumatic brain injury due to a suicide attempt. The patient subsequently recovered enough to be rehabilitated. Traumatic brain injury (TBI) is commonly associated with cognitive deficits and it is important to diagnose and treat victims of TBI as early as possible. There is evidence that medications which protect neurogenesis may be useful in mitigating and potentially reversing morbidity associated with TBI (Singh, 2013). One of these medications is quetiapine, a second-generation antipsychotic typically used to treat schizophrenia. Quetiapine has been shown to significantly decrease blood brain barrier hyperpermeability by preserving tight junction integrity in small animal models (Robinson et al., 2018). This anti-inflammatory effect may also help to preserve neurogenesis in TBI patients. The patient in this case was treated with quetiapine to help protect neurogenesis and recovered enough to be discharged to a rehabilitation unit. This case may

help elucidate the nature of quetiapine's neuroprotective effects in patients who have suffered TBI, but also highlights the need to further investigate other atypical antipsychotics and their potential neuroprotective role in treating TBI.

No. 17

Psychiatric Decompensation From New Immigration Policies and Enforcement at the U.S.-Mexico Border

Poster Presenter: Eric Rafla-Yuan, M.D.

Lead Author: Lawrence Malak, M.D.

Co-Authors: Priti Ojha, M.D., Stephanie Martinez, M.D., Tarina Quraishi

SUMMARY:

The San Diego border region of the United States-Mexico border has been a hotbed of political rhetoric and activity. Significant recent developments have included the stationing of military troops, federal proposition of a "public charge" policy, establishing large scale detention centers, and increased aggressiveness of Immigration and Customs Enforcement (ICE) in the San Diego community. While there has been a motion for doctors to "stay in their lane," numerous medical organizations including the American Psychiatric Association (APA), American Medical Association (AMA), and California Psychiatric Association (CPA) have issued statements and critiques of proposed and enforced changes, as these have measurable effects on psychiatric symptoms. This poster provides a review of recent immigration propositions and policies with the resulting psychiatric outcomes illustrated through a series of vignettes from patients in San Diego County. "R" is a Hispanic teenager treated at a publically-funded program providing wrap-around services for children and transitional age youth who are at risk for homelessness. She currently resides in Mexico but crosses the border multiple times a week to attend her college classes and for her medical appointments. "M" is a gentleman pursuing an asylum case in the US and is seen at a publically-funded clinic focused on the needs of survivors of torture. "A" is a child who was psychiatrically hospitalized for suicidality; collateral revealed multiple exacerbations of psychosocial factors including split custody with one parent in the US and

one in Mexico. A repeating theme of these narratives is the insufficiency of pharmacologic and psychotherapeutic interventions in alleviating symptoms that stem from larger political and societal stressors. Strategies to empower psychiatrists and other clinicians to advocate for their patients are discussed.

No. 18

A Reflection on Ghana's Mental Health System: One Month at Two Hospitals

Poster Presenter: Adjoa Smalls-Mantey, M.D., D.Phil.

SUMMARY:

Ghana has a population of 28 million people yet the country only has an estimated 18 to 25 psychiatrists. Most psychiatric care is delivered by mental health nurses and other health officers. This reflects an expansion in the delivery of mental health services since the passing of the Mental Health Act in 2012. This presentation details my experience and observations from time spent at the Accra Psychiatric Hospital and Navrongo War Memorial Hospital in Ghana during August 2018 as a PGY4 psychiatry resident. Family support for patients, the scope of psychiatrists, and inadequate funding for psychiatric services were evident strengths and weakness of the mental health system. As treatment of psychiatric illness expands more funding, psychiatrists, and mental health workers will be critical for the continued success of Ghana's mental health system.

No. 19

Using IV Ketamine in Outpatient Psychiatry to Stop Suicidal Ideation

Poster Presenter: Lori Calabrese, M.D.

SUMMARY:

Background: Recent inpatient studies examining the effect of single sub-anesthetic ketamine infusions in treatment resistant depression (TRD) have shown promising results in diminishing suicidal ideation (SI). We describe the efficacy of serial titrated ketamine infusions in stopping suicidal ideation and averting ER visits and hospitalizations in a large, naturalistic sample of adult and adolescent outpatients with TRD and complex psychiatric comorbidity in a real-world psychiatry office practice. Methods: This is a

retrospective chart review of 235 adults and adolescents presenting with TRD and complex psychiatric comorbidity in a large real-world psychiatry office practice with > 5400 visits/year. Each patient underwent a 60-90 min comprehensive diagnostic consultation by the single treating psychiatrist. Medical, psychiatric, and psychotherapy records were requested and reviewed when available. Appropriate patients were treated with 6 sub-anesthetic escalating dose ketamine infusions (0.5-1.2 mg/kg over 40-50 min) over 2-3 weeks. PHQ-9 was obtained at baseline and before each infusion. The presence, frequency, and intensity of PHQ-9 Item 9 was analyzed over the course of treatment and correlated to overall decrease in PHQ-9. Suicides, suicide attempts, ER visits and hospitalizations were analyzed over the course of treatment and for an additional 4 weeks. Results: 64% of TRD patients presented with SI. There were no suicides, attempts, ER visits or hospitalizations in this large real-world cohort. SI markedly diminished in 81.8%, and ceased completely in 68.4%. Remission of SI was bimodal, occurring after 1 infusion in 30.6%; the remainder required 3.3 infusions and a dose of 0.75mg/kg for remission of SI. Notably, suicidal patients experienced higher rates of response and remission of TRD to IV ketamine than non-suicidal patients. Conclusions: This is the first report of using serial IV ketamine infusions in a real-world psychiatry office for adults and adolescents with TRD and complex psychiatric comorbidity to safely and rapidly treat severe suicidal ideation and avert ER evaluation and hospitalization. It represents the largest number of patients to date reported from a single site in studies of IV ketamine infusions for TRD and suicidality, and a potential breakthrough treatment option for psychiatrists to provide in their offices.

No. 20
Suicide Attempts and Homelessness in a Nationally Representative Sample of Adults

Poster Presenter: Jack Tsai

SUMMARY:

Suicide is consistently been one of the ten leading causes of death overall in the United States and suicide rates have been increased over the past decade. Suicide and homelessness share many of the

same risk factors, and previous research with small sample sizes have found that suicide rates are higher in homeless populations than domiciled populations. Few studies have examined how strongly homelessness and suicide are linked, controlling for mental health and psychosocial variables, and specifically in veterans (and non-veterans). This study used a large population sample to examine whether homelessness is a factor independently associated with suicide in U.S. veteran and general populations after adjustment for other known associated factors (e.g., demographics, mental illness, substance use disorders, and other psychosocial characteristics). Data on 36,155 adults (3,101 veterans and 33,024 non-veterans) from the National Epidemiological Survey of Alcohol and Related Conditions-III (NESARC-III) were analyzed. The NESARC-III collected data on sociodemographic characteristics lifetime suicidal attempts, lifetime homelessness, structured diagnostic assessments of mental disorders and substance use disorders, and other psychosocial data. The findings showed that among veterans, 24.5% of participants with any lifetime homelessness reported lifetime suicide attempts compared to 2.8% of participants without any lifetime homelessness. Among non-veterans, 23.1% of participants with any lifetime homelessness reported lifetime suicide attempts compared to 4.5% of participants without any lifetime homelessness. Among veterans, homelessness, bipolar disorder, borderline personality disorder, antisocial personality disorder, and heroin use disorder were also strongly associated with lifetime suicide attempts (OR > 2.0). Among non-veterans, homelessness, major depressive disorder, bipolar disorder, and borderline personality were also strongly associated with lifetime suicide attempts (OR > 2.0). Together, these findings show there is considerable overlap in the people who need homeless and suicide prevention services, and thus synergizing homeless and suicide prevention services may better serve high-risk populations.

No. 21
Enhancing Ethics Training for Psychiatry Residents by Integration With a UNESCO Bioethics Unit

Poster Presenter: Joseph E. Thornton, M.D.

Co-Authors: Jessica Marie Khan, M.D., Jacqueline A. Hobbs, M.D., Ph.D.

SUMMARY:

The University of Florida- Veterans Administration (UF -VA) UNESCO Bioethics Unit was established in 2015 under the auspices of the UNESCO Bioethics Chair (Haifa). The mission of the UF-VA UNESCO Bioethics Unit is to promote the teaching of ethics into everyday clinical practice. The UNESCO Universal Declaration on Bioethics and Human Rights (Declaration) was formalized on October 19, 2006. The VA Integrated Ethics Program (Program) was developed through the 1990's and formalized in 2009. This presentation describes the operational synthesis of the Declaration with the Program through the UF-VA UNESCO Bioethics Unit. The UNESCO Universal Declaration on Bioethics and Human Rights has 28 articles covering 5 domains (General provisions – 2 articles; Principles -15 articles; Applications – 4 articles; Promotion – 4 articles; and Final provisions – 3 articles). The strength of the Declaration is its systematic and comprehensive coverage of the bioethics field. The VA Integrated Ethics Program covers 10 ethical domains (Shared decision making, end of life, beginning of life, patient privacy, professionalism, resource allocation, business, research, workplace and government service). The Program has 3 core functions to cover the domains: ethical leadership, preventive ethics and ethics consults. The strength of the Program is its administrative infrastructure to support implementation and data gathering. The University of Florida Health System (UF Health) represents the largest comprehensive health care system in the southeastern USA with six hospitals and six health professions schools. The strength of UF Health for placing ethics into practice is its prime role in education and research. The UF-VA UNESCO Bioethics Unit provides a unique unit within the North American UNESCO Bioethics community due to its joint affiliation with two large hospital systems: The North Florida/South Georgia Veterans Health System and University of Florida Health. The authors demonstrate how the UNESCO Universal Declaration on Bioethics and Human Rights can be used as an overlay tool onto practical ethics programs in order to enhance systematic comprehensive ethics, facilitate discussion on ethical topics between different systems and to enhance comprehensive integrated ethics training for clinical trainees at any

stage of their career. The UF-VA UNESCO Bioethics Unit has promoted activities to support World Bioethics Day, supported resident and faculty presentations at national and international meetings, contributed to an AADPRT approved curricula for psychiatry resident ethics training, organized resident case conferences featuring bioethical issues and promoted incorporating teaching about ethics on daily clinical rounds.

No. 22**The Forensic Psychiatrist and the Public Interest: A Review and Case Report on “Multiple Agency” in Psychiatric Evaluations of Asylum-Seekers**

Poster Presenter: Yi Wang, M.D.

Co-Author: John K. Northrop, M.D., Ph.D.

SUMMARY:

Dual agency, in which a psychiatrist assumes two separate roles—the most frequently cited example being a physician providing both clinical and forensic services—has been explored extensively in the forensic psychiatry literature. Dual agency is generally discouraged on ethical grounds, with the argument that it may compromise the forensic expert's objectivity and thereby damage the client's legal case. In addition, it may undermine the credibility of the forensic expert and of her profession at large. In this poster, we propose another example of dual agency which occurs more commonly than is discussed: that of the psychiatrist acting as political advocate (and possibly even political partisan), in addition to forensic examiner, when evaluating political asylum-seekers. We believe that these two roles—of forensic expert and of political advocate—are guided by different procedures and ethical principles, which may occasionally come into conflict. We believe that this type of dual agency merits acknowledgement and discussion, especially because the question of whether physicians have professional responsibilities to the public interest (e.g. through political advocacy or policy-making), in addition to responsibilities to their individual patients, continues to be fiercely debated. In this poster, we provide a brief review of the literature, exploring how the roles of the psychiatrist as forensic examiner, clinician, and political partisan may come into conflict during psychological evaluations of asylum-seekers. We

present the case of Ms. Z, a 22-year-old woman from Central Africa, who sought psychological evaluation in support of her application for political asylum due to fear of religious persecution in her home country. We look at various aspects of this case to explore how a forensic psychiatrist's political leanings may affect her interpretation of the asylum-seeker's mental status and self-reported narrative. We also use this case to consider how a psychiatric examiner's attitudes toward other overarching social institutions—such as those of religion, ethnicity, or gender— may influence her formulation of the asylum-seeker. We describe the ways in which these attitudes creates “multiple agency,” which, if unacknowledged or unidentified, may harm both the evaluator and the asylum-seeker. Finally, we offer suggestions for mental health professionals providing medico-legal services to asylum-seekers, as well as the institutions training these professionals, on how to anticipate sources of multiple agency, how to recognize it when it arises, and how to avoid it or to minimize its negative effects.

No. 23

The Role of Cytoplasmic FMRP Interacting Protein 1 in Nucleus Accumbens Associated With Cocaine Response

Poster Presenter: Nicholas Lozano

Lead Author: Ozlem Gunal, M.D., Ph.D.

Co-Authors: Kavita Prasad, Ph.D., Azadeh Kamali Tafreshi, Ph.D., Rijul Asri, B.S.

SUMMARY:

Cytoplasmic FMR1-interacting protein (Cyfip)1 has been identified as a risk factor for several neuropsychiatric disorders including schizophrenia, intellectual disability, and autism in humans. We have previously shown that mice carrying a Cyfip1 mutation (Cyfip1+/-) show dysregulated synaptic function and plasticity in the hippocampus. Structural and functional synaptic changes in the nucleus accumbens (NAc) are associated with addiction related behaviors such as cocaine seeking. New evidence on genetic risk factors can help elucidate the response to addictive drugs. To test our hypothesis that cocaine related behavioral responses and synaptic function in the NAc are affected when Cyfip1 levels are reduced, we

performed open field tests and compared locomotor activity in control conditions and in response to cocaine by using an automated video tracking system. Wild type mice display an increase in locomotor response to the administration of cocaine (15mg/kg) in both genders, as expected. This response is blunted in all Cyfip1+/- mice and in male mice more than female. Preliminary data show no difference in GluA1 immunolocalization in the NAc between genotypes under controlled conditions. After cocaine injections, quantification of GluA1 expression shows lower levels in the NAc of Cyfip1+/- mice. Field EPSP recordings in the NAc show comparable post-tetanic potentiation between genotypes. Western blot confirms normal levels of Cyfip1 expression in the NAc of wild type mice. Meanwhile immunohistochemistry shows reduced Cyfip1 expression in Cyfip1+/- mice. These findings provide a novel cellular mechanism that may contribute to cocaine-induced behavioral alterations. Clarifying Cyfip1's role in cocaine response, locomotor sensitization, and NAc plasticity, which is a previously unexamined target, may be relevant for a variety of disease-related genes with similar functions.

No. 24

Challenges of Managing Chronic Pain in a Patient With Active Psychosis and a History of Drug Abuse

Poster Presenter: Kara Marie Narzikul

SUMMARY:

Mr. L., a 41-year-old African-American male with a past psychiatric history of schizoaffective disorder, phencyclidine (PCP) use disorder, opioid use disorder, and alcohol use disorder, presents involuntarily to the inpatient psychiatric unit in an acute psychotic state with both paranoid and grandiose delusions, in addition to both visual and auditory hallucinations. The patient also has a pertinent past medical history of well-documented chronic pain from sickle cell disease, with pain crises occurring approximately twice per month, as well as liver failure due to chronic opioid and acetaminophen use. Additionally, the patient has a complex social history which includes recent release from incarceration after a felony conviction for opioid prescription forgery. During his hospitalization, the patient continually refused to

give a urine sample for a urine drug screen, but did admit to recent PCP, opiate, benzodiazepine, and marijuana use. The medical team considered the differential diagnosis of schizoaffective disorder, schizophrenia, and substance-induced psychosis. The stigma of both the patient's legal background and his history of substance use, compounded with his current psychotic symptoms, presented a challenge to the medical team, who sought to control the patient's chronic pain and address his psychosis. This poster discusses the difficulties of treating chronic pain in patients with a history of substance use, as well as the difficulties of treating chronic pain in acutely psychotic patients. Additionally, this poster examines the efficacy of current strategies for the management of these complex patients, such as utilization of Assertive Community Treatment (ACT) and formation of controlled-substance agreements between caregivers and patients.

No. 25
Post Stroke Depression Frequently Overlooked, Undiagnosed, Untreated

Poster Presenter: Ali M. Khan, M.D.

SUMMARY:

Depression is the most frequently seen neuropsychiatric manifestation in stroke patients. It hampers the ability to undergo therapy and impairs their functional outcome. Depression also increases the risk of suicide in stroke patients, therefore, increasing mortality. The etiology of post-stroke depression (PSD) is complex and reported to be multi-factorial in origin. It also depends on the size and location of the infarct. In addition, family history or prior history of depressive disorders makes them prone to be affected with depression following a stroke. In this article, we will mention various aspects of PSD, as well as the prevalence and the different screening assessment tools used in literature studies. Although there are many available testing tools, little consistency was seen in them being valid or reliable. We will also discuss the pathophysiology of depression in stroke patients with various available options for managing the condition. We will briefly review the use of alternative treatment such as Electroconvulsive therapy (ECT) and Transcranial Magnetic Stimulation (TMS) as well. However, we need further evidence-

based research exploring the screening tool; i.e. universally acceptable for PSD and implementing an effective, non-invasive treatment modality impacting the prognosis. Also, we require further investigations to identify the role of antidepressants in the recovery of stroke patients. Keywords: Stroke, Post-stroke depression, Stroke location, Assessment and Treatment, Post-stroke Depression, Prevalence of PSD, Pathology in PSD, Mood disorders in PSD, Symptoms and diagnosis criteria in PSD, Assessment scales in PSD, Pharmacotherapy and other treatments in PSD, Depression in stroke survivors

No. 26
Rapid Progression of Parkinsonian Symptoms in Lewy-Body Dementia After Administration of Antipsychotics: Case Report

Poster Presenter: Ali M. Khan, M.D.

SUMMARY:

The research is being conducted to find out that if treating lewy body dementia with anti-psychotics rapidly increases Parkinsonian symptoms. According to previous researches, anti-psychotics have shown to cause drug-induced Parkinsonism. This research is based upon whether or not there is any relationship in between the two. This case is of a 60-year-old female patient who lives in an apartment and has no prior psychiatric history. Recently the patient had been getting more and more agitated, paranoid, increasingly withdrawn and did not maintain her ADLs. Patient mentioned being tired, not being able to sleep as people living upstairs play loud music. Upon investigation, there was no loud music being played by the patient's neighbors at night or at any time. Patient also complained of the people living upstairs did not like her and disturbs her which in fact was not true. Patient lives alone in the apartment and used to be active and all household chores were performed by the patient herself but recently patient has been really lazy and keeps lying on the couch and does not perform her chores. Patient has also started threatening people including her daughter. Patient worked in the city before and has been married twice but both resulting in separations and divorce. As per daughter, patient is easily forgetful, repeats things again and again. Patient denies using any drugs or illicit substances and has no significant medical problem. However

according to the daughter patient has a past history of IV heroin abuse (20 years ago) and alcohol abuse.

Poster Session 3

No. 1

Outcomes of an Integrated Program for Co-Occurring Substance Use Disorders and Serious Mental Illness

Poster Presenter: Delia Cimpean Hendrick, M.D.

SUMMARY: Objective: The overall objective was to evaluate a treatment program for men with co-occurring serious mental illness and substance use disorder that included evidence-based integrated dual disorders interventions, family education, supported employment/education, supported housing, and assertive community treatment. Primary aims were to examine completion rates, recovery status, predictors of recovery, and reductions in hospitalization. Methods: Program staff identified participants admitted between 2012 and 2016 and attempted to interview both a family member and the participant, inquiring about overall functioning, family relationships, housing, education/employment, and management of mental health and substance use disorders. Independent researchers reviewed all interview transcripts, analyzed data from medical records, and rated recovery status at follow-up based on mental health, substance use, and functional status. Results: The final sample comprised 80 participants. Sixty-five percent of participants (52/80) completed the residential program, and 39% (31/80) completed or were still engaged in community-based, assertive community treatment. At follow-up, 60% (48/80) of participants were in recovery. The most significant predictor of recovery status was treatment completion: 97% of participants who completed the residential program and completed or remained in assertive community treatment were in recovery at follow-up, compared to 33% of non-completers (Fisher's Exact Test, $p < .001$). Other significant predictors of recovery were greater family involvement and positive discharge status on housing, education/employment, and substance use disorder. All participants showed reduced hospitalizations over time. Those who completed both programs maintained a near-zero rate of

hospitalizations at follow-up, while non-completers experienced an increase in hospitalizations after discharge. Conclusions: Full participation in evidence-based, residential and outpatient co-occurring disorders care produces excellent outcomes.

No. 2

WITHDRAWN

No. 3

WITHDRAWN

No. 4

Understanding Diagnostic Overshadowing in Emergency Medicine: A Comparison of Diagnostic Work Up for Patients With Anxiety

Poster Presenter: Kathryn W. Adams

Co-Authors: Yanina Purim-Shem-Tov, Eitan Z. Kimchi, M.D.

SUMMARY:

Patients enter the emergency department with a chief complaint that leads to a series of diagnostic tests. A patient, whose final diagnosis is determined to be anxiety, may present with a chief complaint ranging from panic attack to shortness of breath to chest pain. However, the latter two chief complaints may lead to more extensive testing than the first (Sung et al, 2018). Patients whose anxiety is felt to be non-cardiac in nature are often more quickly discharged from emergency departments compared to patient's whose anxiety is felt to be cardiac in origin (Basara et al, 2015). At Rush University Medical Center, there is a collaborative effort between the Departments of Psychiatry and Emergency Medicine to give the most effective and efficient care to patients. To evaluate this partnership, we completed a retrospective chart review to compare the diagnostic workup and length of stay for patients who left the emergency department with a final diagnosis of anxiety from 2016 to 2017. The study excluded charts where the patient experienced significant trauma prior to presentation, i.e. sexual assault or violence, and those who were diagnosed with comorbid anxiety and cardiovascular disorder. In total, we reviewed 755 charts. We extracted the following data points from each chart: chief complaint, length of stay,

whether a mental health specialist evaluated the patient, history of a psychiatric disorder, and the diagnostic workup performed in the emergency department. We reviewed the data to determine if the following data were performed: D-dimer, CBC, CMP, BMP, TSH, Troponin, EKG, Chest radiograph, Angiogram, Chest CT, additional imaging, and urine analysis. The majority of chief complaints came from either a psychiatric (i.e. anxiety) or cardiovascular complaint (i.e. chest pain). Those who received a psychiatric consult of evaluation had 133.14 minutes longer length of stay than those who did not ($p < 0.05$). Of the patients evaluated by a mental health specialist, 136 of the 160 patients had a history of at least one psychiatric disorder ($p < 0.001$). Patients with a history of a psychiatric disorder received 2.52 diagnostic tests on average while those without this history received 3.06 tests. Overall, these results indicate that those who present to the emergency department with past medical history of psychiatric illness do not receive the same level of testing and they also stay longer to wait for evaluation/consult from psychiatry. Not only do they not receive the same level of testing, they also stay longer to wait for evaluation/consult from psychiatry. It is a positive step that there is no difference in testing for those with a chief complaint of both chest pain and anxiety. More collaborative training regarding evaluation and assessment of patient with anxiety related complaints in the emergency department.

No. 5

A Quality Improvement Project to Improve Accessibility to Mental Health Care in a Psychiatric Outpatient Clinic

Poster Presenter: Chunzhen Tan, M.D.

Lead Author: Kah Hong Goh, M.D.

Co-Authors: Wei Shyan Lim, M.D., Patrick Phor, Nurul Fuziana Abdul Rahim, Yi Feng Fong

SUMMARY:

This project is a sequel to an earlier study aimed at reducing the first visit (FV) no-show (NS) rate at an outpatient psychiatric clinic in Singapore. NS leads to longer waiting times for patients to be seen in clinics and wastes physician time and clinic resources. Studies have shown that effective interventions can reduce the NS rate resulting in more efficient use of

resources. 30% of all patients registered for FV consultations between Jan 2016 to Jun 2017 at our clinic defaulted their appointments. Of all scheduled FV consults, 35% were intra-hospital referrals, and 35% of these referral were from A&E. Our analysis indicated that 51% of the A&E referrals defaulted their first visits. This is disproportionately higher than the 30% no show rate for FV commonly cited in studies. Our first study followed 3 consecutive Plan-Do-Study-Act (PDSA) cycles. These were targeted at decreasing lead time to appointments, increasing the availability of appointment slots for ED referrals, improving awareness amongst ED staff and simplifying inclusion criteria. The resultant effect was a short lived drop in the NS rate to 15% for one month. However this was not sustained and the clinic saw a gradual climb in NS rates back to the original baseline. 2 main reasons were identified. Firstly, ED doctors surveyed expressed confusion regarding the referral process and options, and information was often lost in the process of handover between rotating doctors. Secondly, there were multiple departments involved in the referral process, including the ED doctors, ED front desk staff, hospital call centre and own clinic front desk and nurses. We hence conceptualized a Coordinated Access approach. Firstly, referrals to our clinic were streamlined into a single workflow to reduce confusion about the different options for referrals. Patients were referred directly from the ED doctors to a clinical coordinator in our department, who would then contact the patient to inform them of the services provided by our clinic and offer them a scheduled visit at a timing that they were agreeable with. If these patients declined a psychiatric consult, they would be provided with information about the relevant mental health conditions and options for support services in the community. This effectively centralised the referral process and did away with a fragmented system, allowing us to more efficiently channel our resources to match patients' needs. The Coordinated Access approach enabled us to provide the patient with access to mental health care in the form that they were most comfortable receiving and granted more agency to patients in need of services. It also freed clinic slots that would otherwise have been occupied by patients who were hesitant to come for psychiatric consultations. The resultant effect has been a sustained reduction of the NS rate

from ED referrals to 30%, improving patient accessibility to mental health care.

No. 6

Collaboration in the Implementation of Behavioral Health Innovations: A Mixed-Methods Analysis

Poster Presenter: Natrina Johnson

SUMMARY:

Research Objective: We aimed to 1) understand the extent to which hospital stakeholders and community partners collaborated during the implementation of behavioral health innovations at 11 Massachusetts community hospitals, and 2) determine whether hospitals which reported levels of systemic collaboration experienced reductions in behavioral health revisits and/or readmission rates. Methods: We collected qualitative and administrative data from 11 community hospitals in Massachusetts. We interviewed 119 hospital management, staff, and community partners from 11 community hospitals. Administrative data from each hospital were analyzed to determine the annual readmission and revisit rates for all individuals admitted to the hospital with a behavioral health primary or secondary diagnosis. We performed a mixed-methods evaluation of the Community Hospital Acceleration, Revitalization and Transformation (CHART) program to reduce rehospitalization and revisits (with reduction aims between 15-20% over 24 months) to the emergency department. (1) We subsequently categorized hospitals according to the Levels of Systemic Collaboration framework developed by the Center for Integrated Health Solutions. (2-5) We estimated the annual readmission and revisit rate one year before and one year after CHART implementation. We compared the change in pre/post outcome measures. Principal Findings: Based on our coding, none of the 11 hospitals studied collaborated at a level 1 (minimal collaboration lacking co-location) or level 6 (full collaboration in a merged integrated practice). Two hospitals collaborated at a level 5 (close collaboration with some shared space) but had contrary, post-implementation outcomes based on administrative data: one had reductions in revisits and readmissions, whereas, the other had increases in both rates. The three hospitals with the greatest reductions in ER revisits collaborated at a

level 3 (basic onsite collaboration) and 4 (close collaboration with some system integration). Two of the three hospitals with the greatest reduction in readmissions collaborated at a level 4. The third hospital with greatest change in readmission collaborated at level 2 (basic collaboration at a distance); this hospital also had the highest baseline readmission rate among all 11 hospitals. Conclusion: The three hospitals with the greatest reduction in ER revisits and two of the hospitals with the greatest reduction in readmissions collaborated at or above a basic level of onsite collaboration. This indicates that co-location, regular communication, and occasional meetings may be key factors contributing to reductions in revisits and readmissions. The two hospitals with the highest collaboration (level 5) had opposite trends in outcome measure. These results suggest that co-located collaboration between providers may be one important, but not solely sufficient factor, in improving rates of revisits and readmissions related to behavioral health.

No. 7

Underutilization of Clozapine: A Case for Reverse Integrated Mental Health Care.

Poster Presenter: Tagbo E. Arene, M.D., M.P.H.

SUMMARY:

Background: The need for an improved standardized care delivery for individuals with Severe Mental Illness (SMI) that is innovative and collaborative cannot be overemphasized. The challenges of treatment of with resistant /or refractory psychotic illness appears to make it likely that Antipsychotic Polypharmacy (APP) may be a common treatment strategy. The use of APP treatment strategy poses additional negative impact in the overall health of the patient, considering that these population of patients are more likely to have an unestablished or a poorly managed established medical co-morbidities. This study aims to reinforce the need for an improved and sustainable integrated system of care to lessen the burden of medical co-morbidities among this population. Methods: Utilizing an existing patients' data, a total 201 patients' with diagnosis of Schizophrenia and Schizoaffective disorders on more than one antipsychotic medications that does not include Clozapine were obtained and reviewed. The goal was

to explore prior patterns of antipsychotic prescribing among these patients who are not on Clozapine; explore episodes of antipsychotic prescription, especially episodes constituting adequate trial; the mean number of different antipsychotics used and given an adequate trial. We attempted to explore the potential reasons and concerns for APP treatment strategy. We also explored patient's substance use, non-adherence versus likely refractoriness of illness as well as demographic data and psychotic illness variables were explored. Results: Based on the information obtained, it was evident that Clozapine treatment was delayed for longer than clinically desirable and the need to have more providers prescribing Clozapine. The delay may have important impact on the quality of life, clinical outcome and health resources utilization among this patient population. However, patients on Clozapine have treatment required regular scheduled clinic visit, medical work ups and ancillary services, hence increased likelihood of early detection and treatment of other medical co-morbidities. Conclusion: Based on our observations in this County clinic, this population of patients are less likely to follow-up with their referral to other specialties for their medical co-morbidities in a different location outside their mental health clinic site and even co-located facility. In this poster presentation, we propose a model of a Reverse Integrated Mental Health Care based on the observed complexity of providing care for this patient population. This model of care considers the psychiatrist as Principal Care Physician and the mental health clinic being the primary medical home. This approach may lessen the burden of patients' and providers' difficulty with navigating and accessing whole person care.

No. 8

A Nationwide Look at the Association Between Socioeconomic Status, Race, and Depression in the United States

Poster Presenter: John V. Lacci Jr.

Co-Author: Alejandra Morfin

SUMMARY:

Depression and suicide have been shown in multiple studies to be a major cause of morbidity and mortality in the United States. Prevalence of depressive disorders have increased in the last few

decades. Prior research shows a link between lower socioeconomic status and an increase in depression risk, along with an increased risk of various other chronic diseases. We in this retrospective study reaffirm this association with newer data from the National Inpatient Sample, along with attempting to measure the actual magnitude of risk based on an approximation of income quartile (via zip-code), based on over 6.5 million discharges from 2014 for any admitting diagnosis. The dependent variable for the multivariate regression analysis is a pre-existing diagnosis of depression that is present based on AHRQ software. We find that patients from the lowest household income quartile, corresponding to a median household income under \$40,000, have a 16.5 percentage point higher odds of depression versus the highest income quartile zip-codes, corresponding to a median household income over \$66,000 (OR 1.165; CI 95% 1.156-1.174). Additionally, we find that race has a very strong association with the odds of having a co-existing diagnosis of depression. Compared to whites, blacks were 40.1 percentage points less likely to have a diagnosis of depression (OR 0.599; CI 95% 0.594-0.604). Asian or Pacific Islander ethnicity had the lowest association with depression as any group, which corresponded to odds of depression 69.9 percentage points lower compared to whites (OR 0.301 CI 95% 0.293-0.309). Our results in totality, with newer data and a larger sample size from 2014, reaffirm prior research that shows that lower socioeconomic status and white ethnicity are major risk factors for depression. We estimate that being in the lowest median household income quartile corresponds to an increased risk of depression of 16.5 percentage points compared to the richest quartile. Additionally, we find that white patients are 3.3 times as likely to have a pre-existing depression diagnosis compared to Asian patients, 1.8 times more likely compared to Hispanic patients, and 1.7 times more likely compared to black patients. These differences may be due to inherent risk by race, differences in cultural attitudes towards psychiatric care, or differences in access to care in general. Our results provide more reason for further research in the area and crafting public health policy that takes into account race and income when dealing effectively with mental health.

No. 9

Challenges in the Management of Treatment-Resistant Depression in the Context of Comorbid Psychiatric Diagnoses

Poster Presenter: Wendy Rocio Martinez Araujo, M.D.

Co-Authors: Asif M. Rahman, M.D., Leena Mohan, M.D.

SUMMARY:

We present a case of a 41-year-old Caucasian male with past psychiatric history of major depressive disorder, obsessive-compulsive disorder, body dysmorphic disorder, anorexia nervosa, restrictive type and borderline personality disorder, at least 3 prior inpatient psychiatric hospitalizations, history of electroconvulsive therapy, 3 previous suicidal attempts, and no significant medical history who presented for suicide attempt by self-inflicted complex full thickness neck laceration. The patient was initially admitted to the surgical intensive care unit for medical stabilization, and later transferred to the inpatient psychiatric unit due to persistent suicidal ideation. During the course of hospitalization, it was revealed that the patient's depressive symptoms were refractory to antidepressant and other psychotropic treatment for greater than two months. As a result, patient was referred for electroconvulsive therapy and long-term inpatient psychiatric hospitalization as the next steps in management. The indexed case highlights the difficulties that we face in dealing with cases of treatment-resistant depression, particularly in the setting of comorbid psychiatric diagnoses.

No. 10

WITHDRAWN

No. 11

Differences in Cognitive Performance in Patients With Major Depressive Disorder Treated With Escitalopram, Venlafaxine, or Vortioxetine

Poster Presenter: Juan J. Fernandez-Miranda

Co-Author: Sylvia Díaz

SUMMARY:

Background Major depressive disorder (MDD) is frequently accompanied by cognitive deficits, although there is not currently a proper assessment

and treatment for them. Patients with response or remission of depressive symptoms still have in many cases residual cognitive deficits. The aim of this study was to compare effectiveness (decreasing in depressive symptoms) and cognitive performance (assessed by clinician and reported by patient) between vortioxetine, escitalopram and venlafaxine at standard doses in patients with MDD undergoing treatment in a outpatient mental health unit in Spain. Method Patients with MDD treated in a mental health unit with vortioxetine 10 mg/d (N=30), escitalopram 20 mg/d (N=30) or venlafaxine 150 mg/d (N=30) were assessed with the Hamilton Depression Rating Scale (HDRS), the Beck Depression Inventory (BDI) [effectiveness], the Montreal Cognitive Assessment (MOCA) [objective cognitive performance] and the Perceived Deficits Questionnaire-Depression (PDQ-D) [subjective cognitive performance] at the beginning and after 12 weeks of treatment. Subjects included in the study had similar scores in HDRS, BDI, MOCA and PDQ-D at the beginning. Subjects with other psychiatric medications or with mental retardation or dementia were excluded. Results After three months of treatment, there were symptomatic improvement, with a significant decrease in HDRS and BDI scores ($p < 0.01$ for the three antidepressants, and $p < 0.005$ for BDI in patients treated with vortioxetine). There were no significant differences after three months of treatment in MOCA scores in escitalopram and venlafaxine groups, but a mild increase in vortioxetine group (26.7 vs 29.1, $p < 0.05$). There were a significant decrease in PDQ-D scores in patients with venlafaxine (11.2 vs 8.7, $p < 0.05$) and more marked with vortioxetine (11.8 vs 5.3, $p < 0.001$), but not in escitalopram group (9.7 vs 10). Conclusions Treatment with Vortioxetine (10 mg/day) showed to be as effective as treatment with escitalopram (20 mg/day) and venlafaxine (150mg/day) in improving depressive symptoms measured with HDRS and BDI in patients with Major Depression Disorder after 12 weeks. And also it demonstrated to improve clearly subjective cognitive performance compared with escitalopram and venlafaxine when measured with PDQ-D. And, contrary to escitalopram and venlafaxine treatment outcomes, to reach a mild improvement in objective cognitive performance, measured with MOCA. Objective patient's cognitive performance and

patient's self-perceived cognitive difficulties should be considered when choosing antidepressive treatments.

No. 12

Young Minority Adult Experiences With Navigating Access to Mental Health Services

Poster Presenter: Carolina-Nicole Herrera, M.A.

SUMMARY:

Vulnerable populations may have problems interacting with health providers or navigating access to mental health care providers. Patient Centered Care (PCC) is thought to improve the ability of vulnerable patients to navigate the health system by strengthening therapeutic alliances and empowering the patient's voice in medical decision making. This qualitative study seeks to understand how minority young adults navigate access to mental health services. We will interview non-White young adults (ages 19-25) enrolled in a Massachusetts Medicaid accountable care organization (ACO) and who used mental health services in 2019. Two health services frameworks (Hudon's Patient Centered Care model and Dixon-Wood's health candidacy model) will guide the semi-structured interviews. Our questions will focus on identification of need, navigation, cultural alignment between health system and patient, therapeutic alliance, sharing power and responsibility, and the illness career. We will perform a thematic analysis and thematic codes will be supplemented by minimal inductive coding. Completed interviews will be coded in parallel with interviewing, which will continue until thematic saturation. We expect to interview 10 to 12 patients between January and April 2019. We will identify key themes associated with patients' perceptions of need, navigation of care, stigma, and shared decision making. This study will inform future efforts by ACOs and other mental health providers to engage young minority adults who may need psychological assessment or treatment.

No. 13

The ADHD Brain Circuit Buddies: A Novel Neuroscience Approach to Educate the Underserved Population of Hempstead, New York About ADHD

Poster Presenter: Nonye N. Okonkwo

SUMMARY:

From adolescence to adulthood, ethnic minorities experience higher rates of untreated stress, depression, and mental health problems, compounded by the lack of access and underutilization of local mental health services [1]. Although the issue is multi-factorial, research shows that skilled physician-patient communication is the foundation for fostering long-term community partnerships that are integral to reducing the pervasive mental illness stigma in the U.S [1]. The "ADHD Brain Circuit Buddies" concept was created to help patients relate to their ADHD diagnosis by associating pre-treatment symptoms with an animated character to underscore how different therapy modalities augment brain functionality. This project utilized industry-standard production applications to create high-quality interactive video infographics, based on existing clinical research and public health data regarding ADHD. Using this interactive video infographics as an educational tool, the "ADHD Brain Circuit Buddies" project aims to allow medical students with particular interests in psychiatry to engage with the underserved population in Hempstead, New York in order to bridge the gap in knowledge regarding ADHD in this community, and help to decrease the stigma that may exist in having a diagnosis of ADHD or with seeking mental health care due to this diagnosis. Hempstead, NY has a population of 55,454 people with a racial breakdown of 56.4% Black, 45% Hispanic, and 5.26% White. Of the residents, 48% speak a non-English language, with 72.5% reporting US citizenship [2]. Our primary clinical site is an outpatient based pediatric clinic located in Hempstead, NY that treats children and adolescents up to age 21. In this clinical and community setting, patients with a clinical diagnosis of ADHD and their family members will be provided with a 15-minute tutorial in both English and Spanish. Additionally, they will be provided static infographic educational tools in the form of Health literacy brochures, as well as "ADHD Brain Circuit Buddies" materials to take home. The quantitative and qualitative outcomes of our educational models will be assessed through a standardized 5-10 question pre and post-test survey. The pre-test survey will collect information regarding: overall comfort with mental health and

ADHD, baseline knowledge, and likelihood of referring a family or friend for treatment. The post-test surveys will measure those same parameters, in addition to: how the training effects referral rates, treatment compliance, and influences the factors perpetuating noncompliance and mental health stigmas. The results of these pre and post-test surveys will be organized into a standard scale and by analyzed to see if there is a significant difference in the patients and families' perception and understanding of ADHD when comparing the use of traditional educational materials (i.e. health literacy brochures) and the novel interactive "ADHD Brain Circuit Buddies" material.

No. 14

A U.S. Psychiatry Resident's Perspective of Telepsychiatry Supervision of Mental Health Providers in Liberia

Poster Presenter: Ashish K. Sarangi, M.D.

Co-Authors: Yasin Taha Ibrahim, M.D., Regina Baronia, M.D., M.A., Nimra Pasha, B.S., Vicki Jeng, B.S.

SUMMARY:

Background Liberia, a West African country, has a population of 4.6 million and an annual GDP per capita of \$352. Liberia suffers from a devastating shortage of mental health providers with only one psychiatrist and one mental health hospital in the country. Mental health services are largely provided by nurses and midwives with a 6-month graduate training in mental health at the Carter Center. After graduation, no supervision or continued education is offered. In 2016, the Global Mental Health program at the Icahn School of Medicine at Mount Sinai started a tele-supervision program in Liberia. Nine senior psychiatry residents provided clinical supervision to 9 Liberian mental health clinicians (MHCs). Each resident had a faculty mentor to discuss cases when needed. The Icahn School of Medicine at Mount Sinai provided the teleconferencing equipment, including 9 Internet hotspots and 9 laptops. Method A psychiatry resident's perspective with the program is discussed with focus on challenges met and rewards achieved. Results The challenges faced include: 1- Wifi connection issues: Out of 16 scheduled supervision sessions, only 8 were held over 8 months course due

to Wifi connection issues that were not easily resolved. 2- Language (accent) barrier: due to my partner's heavy accent in English, we decided to communicate through texting on Vsee instead of direct video conferencing. 3- Very limited psychiatric medication options: Only 6 medications were available in my partner's facility: Haldol, Chlorpromazine, Carbamazepine, Amitriptyline, Imipramine, and Valium. 4- Deficient presentation of cases: Despite having good clinical knowledge, my partner's presentations usually missed sufficient DSM-5 diagnostic criteria as well as proper screening for relevant differential diagnoses. The primary rewards included: 1- Tangible improvement in confidence in managing cases was reported by MHCs. The program received a recognition letter from the Liberian Ministry of Health. 2- Gaining appreciation of the huge gap in mental health services in Liberia as an example of low-income countries. It was a gratifying experience providing assistance to a much-needed population. 3- The opportunity to be innovative in treating mental illness using very limited resources. Gaining a greater degree of familiarity with older mental health medications was a major plus. 4- Obtaining the skills of using tele-psychiatry as a tool to improve mental health services in low-income countries. Conclusion Despite multiple challenges, tele-psychiatry supervision is a promising strategy in training local mental health providers in low-income countries. This type of intervention offers a very rewarding training experience in psychiatry. Future research on the objective effectiveness of such programs is warranted.

No. 15

Culturally Driven Mental Health Care in Hmong and Cambodian Refugee Populations

Poster Presenter: Melanie Scharrer, M.D.

SUMMARY:

Intro: In the wake of the Vietnam war and Cambodian genocide, approximately 8,000 Hmong and Cambodians have settled in the Madison area. Many of these individuals live with severe health problems, including depression, post-traumatic stress disorder (PTSD), and chronic pain. These communities, through collaboration with local mental health agencies, academic centers, refugee

services, and government agencies, developed a culturally-driven model of mental health care for Southeast Asian refugees. Methods: In 1989, leaders from the Hmong and Cambodian communities partnered with county mental health. The design and building of programs took place at community locations and in-home visits. Local Hmong leaders identified goals of engagement of elders in a supportive, community environment. Kajsiah House created space where elders can be together and receive care for mental health issues. In 1995, the Cambodian community built a Buddhist temple, facilitating engagement in the Khmer heritage. In conjunction with traditional Buddhist teachings and meditation, on-site psychologists offer a culturally-driven model of CBT for PTSD, integrated with the daily rhythms of the temple. Both programs include a shared meal, prepared by community members in a traditional style. Participants grow and harvest seasonal vegetables in community gardens. Other integrated services include physical therapy, Shamanic healing practices, massage, acupuncture, flu shots, blood pressure screenings, and women's groups. Cultural art and dance utilize traditional forms of expression, facilitating healing and connecting participants to cultural values. On-site psychiatrists are familiar with cultural idioms of anxiety, PTSD, or depression. Traditional herbal medicine treatments are taken into consideration if prescribing western medication. Linguistically and culturally fluent case managers provide on-call mental health crisis intervention services, culture brokering and translation for medical appointments, drivers licensing, and social services applications, including citizenship. Results: Hmong and Cambodian communities experience mental health concerns, poverty, and isolation at higher rates than the general population. Linguistic and cultural barriers limit access to resources, especially in the traditional western medical clinic model. Since 1985 there have been no suicides and no mental health hospitalizations in the community participants. Conclusion: Community mental health care provides a unique opportunity to creatively partner with cultural communities, overcoming traditional barriers in getting mental and physical healthcare needs met. Culturally Driven care begins in the community with the community definition of needs, goals, practices. Adapting evidence-based practices

to fit the clients' culture results in the delivery of culturally competent care and healing in the community setting.

No. 16

Measuring Post-Discharge Treatment Outcomes of Clients in Community-Based Mental Health Care: The Need for Benchmarks and Best Practices

Poster Presenter: Rajeev Ramchand, Ph.D.

SUMMARY:

Background: Providers, payors, and consumers are increasingly interested in long-term, post-discharge outcomes for clients in outpatient mental health treatment. Such information can provide rich insight on clients' long term-outcomes and, if done appropriately, the opportunity to reinforce strategies and tools gained in treatment and offer an opportunity to reengage for clients who might benefit from additional treatment sessions. However, following-up with behavioral health clients is a notable challenge and there currently exist no guidelines for clinics interested in conducting this kind of outreach nor benchmarks for clinics to gauge performance. Methods: Cohen Veterans Network (CVN) is a network of behavioral health clinics offering low or no-cost behavioral health care to veterans and their families. Beginning in January 2017, case managers at each of CVN's existing 10 clinics were instructed to attempt to contact clients 3-, 6-, and 12-months post-discharge to check-in and assess their quality of life with a specified instrument. Case managers were specifically instructed to make three attempts by phone, but if a former client refused the follow-up assessment they were not re-contacted. A concurrent literature review was conducted to identify relevant thresholds to monitor performance. Results. Between January 2017 and November 2018, 2986 clients were discharged and eligible for either 3-, 6-, or 12-month follow-ups. In aggregate, attempts were made for 27% of eligible discharged clients at 3- and 6-months, and 40% of eligible discharged clients at 12-month assessments. However, trends over time showed increased compliance, with monthly peaks of 40% for 3-month discharge follow-up contacts and 60% compliance of 6- and 12-month follow-ups. Of those attempted, between a third and 45% provided valid, outcome data with higher rates

at the 3- than the 6- and 12-month assessments. We were not able to identify any benchmark data. We assumed the “gold standard” to be aggregated data from randomized control trials of Cognitive Processing Therapy for persons with military-related post-traumatic stress disorder, which achieved follow-up rates of 69% at 3-months (1 study), 69% at 6 months (1 study), and 50% at 12 months (1 study). Other pseudo-benchmark data derives from HEDIS measures of 30-day follow-up rates of patients discharged from hospitals for psychiatric diagnoses, which in 2016 ranged from 35% to 53%. Conclusion. Community-based behavioral health care providers like CVN are increasingly interested in conducting post-discharge follow-up contact with their clients, and payers and consumers may increasingly expect this service. Best practices and benchmarks are needed to guide clinics seeking to conduct follow-up to evaluate their performance and seek evidence-supported ways to improve their performance.

No. 17

Pink Appointment Cards Improve Outpatient Mental Health Follow-Up

Poster Presenter: Aaron Gallagher

Co-Authors: Rachel Tenney, Sarah Menchaca, Alissa Peterson

SUMMARY:

Background: Following discharge from an inpatient psychiatry unit, patients who do not attend their first outpatient mental health appointment are more likely to be readmitted within 30 days. With an average cost of \$50,000 per inpatient psychiatric hospitalization at Zuckerberg San Francisco General (ZSFG), low outpatient mental health appointment attendance, and consequently high recidivism, represents health care dollars that could be better spent. More importantly, patients who do not attend their first outpatient mental health appointment are at higher risk for suicidal behavior and completed suicide, decreased medication adherence, and decreased future use of outpatient mental health services. This quality improvement project sought to increase attendance at outpatient mental health appointments following discharge from the Inpatient Psychiatry Unit at ZSFG. Methods: Patient discharge data from April 2017 indicated a follow-up appointment attendance rate of 55% for patients

discharged from the ZSFG Inpatient Psychiatry Unit to the community. An in-depth gap analysis was conducted to understand patients’ barriers to attendance. Patients (n=21), doctors, nurses, social workers and outpatient providers (n = 40) were surveyed to identify barriers to attendance and interventions to mitigate those barriers. Patients identified either an appointment card or transportation assistance as the most desirable interventions. Considering cost and resource availability, the chosen intervention was a patient-centered appointment card. The design of the card included a bright pink color to enhance recognizability. Appointment details were filled out by hand during face-to-face meetings between patients and discharge social workers to encourage patient input and engagement. Following the appointment card intervention, 4 months of patient records (n=100) were reviewed to determine the percentage of patients who made their first outpatient appointment after discharge to the community. Results: Post-intervention, the attendance rate at the first outpatient mental health appointment following discharge from the ZSFG Inpatient Psychiatry Unit increased from 55% to 64%. This procedure will continue to be implemented in the ZSFG psychiatry unit going forward. Conclusion: Simple, cost-effective interventions that increase patient engagement and simplify the discharge process can increase rates of attendance at first outpatient mental health appointment following discharge from the inpatient psychiatry unit. Implementation of similar interventions at peer institutions may increase the number of patients who become connected to community mental health care, and subsequently decrease the risk of suicidal behaviors, increase medication adherence, and reduce readmission rates.

No. 18

Behavioral Health in a 2017 Population of 8.5 Million United States Health Plan Customers: Presentation and Costs in Medical and Specialty Settings

Poster Presenter: Gary R. Beard, M.S.W.

Co-Author: Liana D. Bruce, Ph.D., M.S.P.H.

SUMMARY:

BACKGROUND: Serious mental illness costs the United States over \$193 billion per year in personal earnings losses. While 20% of U.S. adults are estimated to have mental illness, many do not receive treatment even with behavioral health coverage. As new evidence emerges about connections between mental and physical health outcomes, health plans are seeking to improve behavioral healthcare access to quality while controlling costs. Questions remain about the value of treatment in behavioral health specialty versus primary care settings. Our objective was to describe and compare behavioral health presentation, diagnosis, costs, and treatment by setting.

METHODS: Cigna* analyzed 2017 claims data from 8.5 million customers in preferred provider organization plans with medical and behavioral benefits. Using ICD-10 codes, behavioral presentation cases were determined in two phases: first, as major diagnostic code of 19: mental health or 20: substance use disorder (excluding brain injuries, intellectual disabilities, and learning disorders). Second through 5th diagnostic codes were examined for a set of behavioral codes. Setting was classified according to treatment service provider: behavioral specialty, medical, or both. The behavioral specialty setting classification comprised claims from free-standing behavioral facilities for treatment of mental illness or substance use disorders, mental health or substance use disorder wards in general hospitals, or outpatient treatment with licensed behavioral health providers: psychiatrist, psychologist, social worker, professional counselor, marriage and family therapist, or pastoral counselor. Age was broken into five categories: 0-12, 13-17, 18-25, 26-64, and 65+. Costs were calculated as total medical spend per customer per year.

RESULTS: 2.1 million (25%) of claims were identified as presenting with a behavioral condition. Among the 1.1 million (12.7%) of those with a primary behavioral diagnosis, 4.8% were treated in behavioral settings only, 6.1% were treated in medical settings only, and 2.2% in both. Except for adolescents, customers from all age groups were most likely to present to medical versus behavioral specialists. Those with behavioral diagnoses had costs twice as high as those without.

CONCLUSIONS: Our findings indicate opportunity for medical specialists to better serve customers with behavioral

diagnoses by treating the condition or referring to a specialist, representing a \$2,000 savings per customer in medical costs. Better understanding behavioral health presentation, diagnosis, referrals, costs, and treatment settings can help providers and health plans identify opportunities for appropriate care coordination and escalation when necessary. Improvements in these areas will ideally reduce disability, economic hardship, and death for the U.S. population. *"Cigna" as used herein refers to operating subsidiaries of Cigna Corporation including Cigna Health and Life Insurance Company and Cigna Behavioral Health, Inc.

No. 19
Prevalence of Trauma History Among Veterans Psychiatrically Admitted to James J. Peters VA Medical Center

Poster Presenter: Lawrence Vaynerchuk, M.D.

Co-Author: Rachel Freydin, M.D.

SUMMARY:

Military sexual trauma (MST) is a prevalent and enduring problem affecting veterans. It is associated with extensive negative sequelae including . suicidality, somatization, substance abuse, homelessness, and psychosocial dysfunction. While the Veterans Health Administration (VHA) recommends a universal screening process for MST, there are no known studies to date regarding prevalence of MST in inpatient psychiatric patients. In this study, all electronic medical records of patients who were psychiatrically admitted in 2017 at James. J. Peters VA Medical Center in Bronx, NY were reviewed for positive screens of various types of trauma: adult MST, adult non-military sexual trauma, adult physical abuse, childhood sexual abuse, and childhood physical abuse. The data showed high rates of lifetime history of abuse (85.7% female inpatients, 35.8% of male inpatients), MST (37% and 8%, respectively), and childhood sexual trauma (55.7% and 23%, respectively). These rates are significantly higher than those found in other studies of patients in the VHA system, as well as the general population. These findings highlight the importance of regular screening in this population to better inform comprehensive assessments and subsequent targeted treatment, to effectively

address the patients' medical and psychological well-being.

No. 20

Non-Combat Veteran Suffering From PTSD

Poster Presenter: Morgan Torcasio

Co-Author: Nita V. Bhatt, M.D., M.P.H.

SUMMARY:

J.T. is a 59-year-old Caucasian male with a history of alcohol use disorder and multiple remote domestic violence charges who voluntarily admitted himself to the VA hospital with homicidal ideations. Over the prior 6 months he had progressing episodes of palpitations, diaphoresis, smothering sensation, distal extremity paresthesia, paranoia and violent homicidal ideations lasting approximately 10-15 minutes increasing from once every 2 weeks to 3-4 times per week. These episodes of increased arousal which he described as "combat mode" began approximately 1 month after the patient moved into a shelter and were provoked by minimal triggers such as someone walking too close to him or hearing other people whisper. Although the patient was very guarded about his time in the military only sharing that he was non-combat, he did report physical abuse during childhood from his step-father and expressed delusions of personal memories of his mother repeatedly trying to murder him before the age of 12 months. Physical examination and extensive medical-work up were within normal limits. The patient was diagnosed with PTSD and was started on venlafaxine. Both the high incidence of veterans with reported childhood abuse and comorbid psychiatric conditions and this case, exemplify the necessity of addressing adverse childhood experiences in creating a sense of lack of belonging. This may play a role in the motivation of men and women in joining the military to find their place and subsequently lower their resiliency to developing PTSD in the future.

No. 21

Associations Between Adverse Childhood Experiences and Pain

Poster Presenter: Jeffrey M. Brown, D.O.

SUMMARY:

Background: A history of adverse childhood experiences has been shown to be associated with multiple pain syndromes (Davis et al., 2005). In this analysis we investigated the association between adverse childhood experiences and subjective reporting of pain among patients seeking psychotherapy in a large outpatient clinic in the Northeast. Methods: 308 patients seeking outpatient psychotherapy and medication management completed the Adverse Childhood Experiences Questionnaire (Felitti et al., 1998) as part of the standard intake self-report packet and consented to participate in this study. Patients also reported on whether they were currently experiencing pain problems, the severity of their pain on a scale of 0 (none) to 10 (severe), and their perceptions of whether their pain is adequately controlled. Results: Results suggested that 57% of the patients seeking psychotherapy services reported having ongoing problems with pain. The average pain severity rating was 3.14; 38.3% of the sample reported their pain to be a 5 or greater. Of the patients reporting pain, 32.7% of them reported feeling that their pain was not being adequately controlled. The same sample of patients also reported a high number of ACEs. The average number of ACEs reported was 4.29. Only 8% of the sample reported having no adverse childhood experiences and 58.9% reported 4 or more ACEs. The most frequent type of ACEs were those related to parental separation/divorce (64.9%) followed by emotional abuse (57.1%), and lastly emotional neglect (56.1%). We next explored the relationship between ACEs and reports of ongoing physical pain. Results suggested that those reporting ongoing problems with pain had significantly ($p < .001$) higher ACEs ($M = 4.86$) compared to those without pain ($M = 3.46$). The same was true for all ACE categories (all p 's $< .01$). Severity of pain was also significantly correlated with the total ACE score ($r = .218$, $p < .001$) and all ACE categories (all p 's $< .01$). Reports of feeling that one's pain was not adequately controlled, however, was not predicted by one's ACE score. Conclusions: Our results suggest that outpatient psychotherapy patients are very likely to have a history of adverse childhood experiences as well as ongoing problems with pain. Our results also suggest that ongoing pain problems and pain severity in adulthood is in part associated with

growing up in an environment characterized by abuse, neglect, and household dysfunction. These findings have implications in generalized disease prevention and chronic pain treatment, especially for patients with a history of trauma and childhood adversities.

No. 22

WITHDRAWN

No. 23

WITHDRAWN

No. 24

Determination of Genetic Changes in the Etiology of ASD in Twins by Whole Exome Array

Poster Presenter: Pinar Algedik Demirayak

Lead Author: Ender Coskunpinar

Co-Authors: Ceyda Hayretdag, Cumhuri Ekmekci, Ozlem Gunal, M.D., Ph.D., Umut Agyuz, Burcu Hasturk, Halime Yildirim

SUMMARY:

Background: Autism spectrum disorder (ASD) is a neurodevelopmental condition of heterogeneous etiology. Twin studies provide strong evidence that genetic factors have a major role in the etiology of ASD but in the majority of patients the underlying genetic cause of the disease is unknown. The aim of our project is to elucidate the pathophysiology of the disease by studying genome-wide differences in twins and revealing the genetic changes responsible for the etiology of autism. Methods: Six monozygotic twins and one dizygotic twin were included in the study. Signed consents were obtained from parents. Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria were used for diagnosis of ASD. In addition, Childhood Autism Rating Scale, Social Communication Questionnaire (current version) and Turkish version of Aberrant Behavior Checklist (ABC) were used. DNA was isolated from peripheral blood samples. OneSeq target enrichment kit was utilized to prepare sequencing libraries which were sequenced on the Illumina NextSeq platform. The data were analyzed with Agilent SureCall v3.0 Software (1-3). After detecting different and mutual SNPs inter and intra twin siblings, we annotated the selected variants using SNPexus, all reference and clinical validations are obtained from ClinVar.

Results: Bioinformatics analysis have revealed 110 disease-related genes, and after further filtering, we have identified 44 SNPs. Significant associations were identified for 6 different genes, including known ASD candidate genes: FMN2, KCNQ2, NOTCH3, TMRC6A, SHANK3, SLC6A4. Conclusion: Our results provide an independent evidence for known ASD genes and highlight other genes, which we will further investigate in a larger sample, and confirm with whole genome sequencing to improve the understanding of the genetic basis of ASD.

No. 25

A Barbershop-Based Intervention for Destigmatizing Mental Health Among African-American Men

Poster Presenter: Francois Williams

SUMMARY:

In the African-American community, the barbershop, presumably a space for cutting hair, actually operates as a political space through its facilitation of meaningful everyday Black talk. The historic and contemporary centrality of the Black barbershop has extended into social, political, and public health realms. The barbershop serves as a site for dialogue, discussion, and dissension within the community. Fade-A-Way Cutz Barbershop whose primary purpose is not medical, in fact, serves important medical functions in the West End neighborhood of Atlanta. Fade-A-Way Cutz has become a public health vehicle for Morehouse School of Medicine students to persuade and mobilize the Black men in the community to reduce hypertension, through the Cut Hypertension program. The Cut Hypertension program is a multidisciplinary coalition of Morehouse School of Medicine student volunteers who take blood pressures of patrons and barbers, on a biweekly basis, in an effort to reduce health disparities in the West End. Men who screen positive for hypertension are referred to Morehouse School of Medicine's student and resident ran health center that provides free health care on Saturday mornings. Several studies suggest that individuals experiencing depression are at high risk of developing hypertension. Depression increases the risk of uncontrolled hypertension, as well as being predisposed to stroke and ischemic heart disease. The 2000 CARDIA study demonstrated that

depressive symptoms are predictive of later hypertension incidence in young adults, particularly African-American men. Connecting the current blood pressure activities of Cut Hypertension, with a robust mental health campaign, that included depression screenings and mental health forums would further reduce health disparities in the West End neighborhood and further the mission of the Helping Hands Grant Program. Merging the depression screenings with the current blood pressure screenings would allow the project to be sustained long after the funding period has expired and would serve as a synergistic model that could be replicated nationally so that men in barbershops could receive both screenings.

No. 26

The Launch of a Substance Use Disorder Initiative in a Student-Run Free Clinic Mental Health Program

Poster Presenter: Ben Shuham

*Co-Authors: Claire Louise Mann, M.D., M.Sc.,
Adrienne I. Rosenthal, Alexandra Morgan Saali,
Jeremy Sherman, Craig Katz, Samuel Powell*

SUMMARY:

Background: Members of the East Harlem community experience higher rates of mental illness and substance use compared to those in other neighborhoods in New York City [1]. To address these disparities, the East Harlem Health Outreach Partnership (EHHOP), a primary care clinic for uninsured adults run by the students of the Icahn School of Medicine at Mount Sinai, created a free, student-run, psychiatrist-precepted Mental Health Clinic (MHC) in 2008. This presentation will describe the EHHOP MHC's new Substance Use Disorder (SUD) initiative. This initiative was launched to bolster EHHOP's ability to screen, triage, and treat patients with SUDs. Many EHHOP patients with diabetes and comorbid SUDs (especially Alcohol Use Disorders - AUD) were having trouble managing their diabetes, with rising HbA1Cs even with increasingly daily insulin dosages. This phenomenon was consistent with a known association between heavy alcohol use and decreased adherence to diabetes self-care measures [2,3] and highlighted a deficiency in EHHOPs ability to identify and manage comorbid substance use and chronic medical illness. Methods: EHHOP patients needing focused mental health care

are referred to the MHC for psychotherapy and medication management. MHC runs biweekly with eleven student providers who each see a small caseload of patients, providing services for over 40 EHHOP patients. The SUD Initiative consists of three phases, with the goal of creating a consistent screening, triage, and treatment path for EHHOP patients with SUDs. Phase 1, which began in April 2018, involves screening all new and existing EHHOP Main and Mental Health Clinic patients for SUDs with the AUDIT tool for AUD. Phase 2 of the project develops a triage and treatment path for those EHHOP patients who screen positive, or who have previously diagnosed SUDs. Phase 3 involves the maintenance and improvement of the pathway for future EHHOP patients. Results: Since April 2018, 123 clinic patients have been screened, yielding 14 positive screens (11.3%). Positive patients were triaged successfully, and are either being followed in EHHOP Main or MHC. Phases 2 and 3 of the Initiative are currently in progress, with continuing data collection efforts underway to see if the interventions improve patient outcomes, especially related to lowering A1Cs in those patients with type 2 diabetes. Conclusions: The EHHOP MHC serves an important role in providing mental health care to EHHOP's high-need patient population. Phase 1 of the SUD initiative has demonstrated that patients with possible SUDs can be detected by simple screening. Phases 2 and 3 of the SUD Initiative aim to show that a direct and convenient referral pathway for patients with SUDs can improve the triage and treatment of this patient population in both medical and mental health settings.

No. 27

Project Prevail: Capturing the Roots of Addiction Through the Development of a Central Massachusetts Teen Mentorship Program

Poster Presenter: Margret Chang

SUMMARY:

A partnership between the University of Massachusetts Medical School and a local recovery high school has culminated in a medical and nursing student taught health promotion and disease prevention curriculum among adolescents with a history of unhealthy substance use. The teaching curriculum is entering into its third year of

implementation and addresses topics such as nutrition, mental health, Naloxone training, self-advocacy, and resume building. Each year the curriculum has sought student and stakeholder feedback to improve the quality of the course content. Over time the curriculum has become less information-based and more interactive with activities that encourage self-reflection and coping strategies. We are working to incorporate resilience education, sexual health, driving safety, and CPR or First Aid into the coming year's curriculum. In addition, our curriculum has empowered the students to participate in a series of panel sessions aimed at educating healthcare providers locally about substance abuse in adolescents. These panels have led to a video project, driven by the ideas and thoughts of the students, that will be used in an upcoming webinar sponsored by the National Library of Medicine.

No. 28
Cognitive Behavioral and Creative Arts Style Therapy in East Harlem Adolescents With Depressive Symptoms

Poster Presenter: Roxanna Nahvi

SUMMARY:

Over one quarter of adolescents in East Harlem have symptoms of depression or have attempted suicide. However, East Harlem is ranked below average for receiving treatment for depression. Cultural barriers to more conventional treatment for depression and limited resources contribute to the problem in this underserved community. Cognitive behavioral therapy (CBT) is an evidence-based therapy that has been proven to significantly decrease depressive and anxiety symptoms in the general population, including adolescents. Furthermore, evidence supports the benefit of creative arts therapy, including art, music and dance therapy, for treatment of adolescents with depression. Here, we propose a combination of CBT and creative arts therapy is effective at attenuating depressive symptoms in adolescents in an underserved community. Furthermore, medical student training in CBT and creative arts therapy will increase awareness and understanding of the different treatment modalities in psychiatric illnesses. Participants ages 13-17 will be recruited from

Metropolitan Hospital using the Pediatric Symptom Checklist-Youth Report (PSC-Y) to screen for depressive symptoms. Eligible patients will participate in the CBT-creative arts style therapy for 8 one-hour long sessions, completing the PSC-Y after every two sessions. PSC-Y scores will be calculated as percent change from baseline and compared to a control group not participating in the combined therapy. Medical students trained on CBT and creative arts therapy will complete a survey before and after training to qualitatively assess comprehension on mental health therapies. Challenges in developing such a program in an underserved community are continuity of care and distrust of novel therapies in mental health. The program will incorporate patient education on mental health to mitigate these challenges.

No. 29
Expanding Mental Health Services at a Student-Run Free Clinic Including Screening, Transportation, and Education

Poster Presenter: Rohini Chakravarthy

Co-Author: Meredith Monsour

SUMMARY:

Shade Tree Clinic (STC), the student-run free clinic associated with the Vanderbilt University School of Medicine. STC has several opportunities for addressing the mental health needs of our population in a more systematic way. Volunteer training, patient screening, and no-show rates were identified as areas for improvement. A two-hour, culturally-sensitive mental health training based upon "Mental Health First Aid" was created for an audience for student volunteers. The PHQ-9 and AUDIT-C were integrated into routine intake processes at the clinic. Patients with mental health needs were offered transportation through Lyft Concierge to prevent transportation-related missed mental health appointments. Training: In the fall, 40 nursing and medical student volunteers participated in a mental health training. The training included information on crisis assessment and common mental health diagnoses. A subsequent training specifically on motivational interviewing was offered in the spring. Surveyed students reported improvements in all domains measured: screening for mental health needs, addressing suicidality,

motivational interviewing, and knowledge of local mental health resources. Screening: Since starting this program in September, 604 screenings for 231 unique patients were completed. This represents 82.5% of our total population. As a result of these screenings, we identified 19 patients with positive PHQ-9 scores (>10). Social work has provided over 77 mental health referrals this year, which is an increase from 60 referrals two years ago.

Transportation: In total, 29 rides have been completed, serving 6 unique patients. There has not been a significant change in show rates. The three-month show rate was 39% in Quarter 3 compared to 43% in Quarter 1 when no transportation was offered. There has been an overall increase in the total number of patients scheduled to meet with a psychiatrist, likely due to increased screening efforts. After surveying patients in quarter 3 we discovered that several patients preferred taking the bus or using their own car. As a result, we began offering gas cards and bus passes but it is too early to see the impact of this on show rates. Participation in the Helping Hands Grant Program provided the opportunity to increase student volunteer knowledge of common behavioral health problems and a better understanding of the mental health safety net. Increased investment in screening, led to increases in referrals to community resources and the monthly Shade Tree Psychiatry Clinic. While offering transportation had no impact on clinic show rates, we learned many lessons about the logistics of offering this service, patient transportation preferences, and identifying the appropriate patients for this service. There may be a subset of patients who would otherwise not receive care if it were not for these transportation services, but it is challenging and resource-intensive to identify who might benefit.

No. 30
Community Mental Health Seminars Reliably Improve Parents' Recognition of Mental Illness and Encourage Open Dialogue

Poster Presenter: Asmita Mishrekar

SUMMARY:

According to the National Alliance on Mental Illness, approximately half of all chronic mental illnesses begin by age fourteen, and a third of students with a

mental health condition drop out of school. In part, the adverse effects resulting from mental illnesses in adolescent populations are due to a lack of awareness and open dialogue about mental health, leading to a dearth in accessing proper treatment and resources. Our project explores the effect of mental health seminars on the knowledge, beliefs, and attitudes of underserved families regarding conditions like anxiety, depression, and substance use disorders. This project highlights which resources and educational workshops were most significant in facilitating a discussion about mental health within underserved communities. We hypothesized that if community members are involved in a discussion about mental health, then individuals will attain a higher level of knowledge, more positive beliefs, and constructive attitudes toward mental health at the end of each session. We conducted three seminars throughout the 2018-2019 academic year, during which twenty-four English- and Spanish- speaking adults completed a Likert scale-based questionnaire preceding and following each seminar. Analysis showed that mean scores increased across all five survey questions. These results indicate that seminar attendees report an increased awareness for issues surrounding mental health. Future direction includes expanding our sample size with upcoming seminars in order to gain insight into specific topics that might require further focus and elaboration.

No. 31
Helping Hands in Houston: A Mental Health and Wellness Curriculum for Afghan Refugees and Honoring Stories

Poster Presenter: Sally Huang

Co-Author: Sophia Banu, M.D.

SUMMARY:

Background: Refugee communities experience a large burden of mental health disorders but frequently originate from regions with low mental health literacy and high levels of stigma surrounding mental health. Goal/Hypothesis: The goal of this intervention was to design and implement an educational pilot program that would increase mental health literacy and decrease stigma surrounding mental health in a refugee population. Methods: Using the Health Belief Model, we adapted

a mental health curriculum written for victims of torture for use in an Afghan refugee population. We coordinated a group of medical trainee volunteers who taught a series of 8 trauma-informed mental health literacy courses using this curriculum designed to raise awareness, decrease stigma, and begin conversation about mental health problems in the Houston Afghan refugee community.

Participants were given pre- and post-curricular surveys on attitudes towards mental health and attended a final focus group. Results: Over 20 women attended at least one of the classes, and 7 women attended at least 6 out of 8 classes, our criteria for completing the course. 6 women completed the course and pre- and post- curricular surveys on attitudes toward mental health. In pre- and post-curricular survey responses, class participants exhibited positive changes towards mental health and mental health care topics on most questions. The curriculum was well-received; in the post-course focus group, participants noted that they appreciated the opportunity to discuss these sensitive topics and believe that even more dialogue will benefit their community. Their desire for continuing courses will be met with additional curricula related to parenting and childcare, to be implemented in Summer 2019. Conclusions: In this pilot study, we conclude that trainee-lead mental health courses are a possible solution for engaging refugee communities in discussions about mental health, increasing mental health literacy and decreasing stigma. Larger studies need to be undertaken to prove the effectiveness of this intervention. (The second half of our Helping Hands Grant, the Honoring Stories Project, is still underway and will be discussed in the final poster as well.)

No. 32

Mind Matters: Improving Mental Health in Rural Communities Through Patient Education

Poster Presenter: Jade Avery

SUMMARY:

Health equity in the field of rural mental health is an ongoing concern that deserves our attention. Rural populations are faced with geographic isolation, reduced access to mental health treatment, provider shortages, and stigmatization of mental health conditions; furthermore, individuals in rural areas

demonstrate increased rates of drug overdose deaths and limited access to substance abuse treatment services (1, 2). Residents of small towns far from larger metropolitan areas reported significantly less treatment for their mental health conditions than residents of cities, suburban areas, or rural areas adjacent to larger metropolitan areas (3). A 2015 Community Health Needs Assessment conducted in rural New Hampshire and Vermont surveyed five regional hospitals, all of which listed mental health and substance misuse as key priority areas. Nearly one in ten community respondents indicated difficulty accessing mental health services in the past year (4). Given these inequities and the requests voiced by community residents pertaining to mental health, there is a clear need for strengthening mental health resources in our underserved rural community. The goals for the Mind Matters program were to improve mental health equity in our rural underserved community by providing patient focused mental health education and outreach. Our mission was to increase mental health confidence through a series of student-led educational sessions that focused on identifying common mental health conditions and exploring treatment and management recommendations. We held these sessions in conjunction with local community health organizations. All sessions had a pre and post session evaluation survey for participants to complete. This survey included questions that explored health confidence and the effectiveness of our sessions. Our data has demonstrated that • 81.1% of survey participants agreed or strongly agreed that they learned something new about mental illness after our sessions. • 72.2% of survey participants agreed or strongly agreed that they felt more confident about their knowledge of mental illness after our sessions. • 77.8% of survey participants agreed or strongly agreed that they felt more confident that they could seek out support for their mental illness after our sessions. • 75% of survey participants agreed or strongly agreed that they felt more ready to deal with mental health issues after our sessions. • 80% of survey participants agreed or strongly agreed that they felt that they can advocate for their mental health needs after our sessions. We completed a total of 8 educational sessions from September to June. Our work has been very meaningful to

ourselves and hopefully our community partners. We have received excellent feedback from both our partner organizers and our participants.

Saturday, October 05, 2019

Poster Session 4

No. 1

A Case of Functional Hallucinations in Neurocognitive Disorder

Poster Presenter: Mia D. Kunitomo

Lead Author: Marcus Hughes

Co-Authors: Douglas Opler, M.D., Bishara Bhasi, M.D.

SUMMARY:

Background: Functional hallucinations are those which occur only in the presence of an external stimulus of the same sensory modality (Jyoshi and Shakya 2017), such as hearing voices only when the sound of the sink is present. Since first described in the 1860s by Kahlbaum, a German psychiatrist, few cases have been reported. Functional hallucinations have been described in schizophrenia (Rajkumar 2012, Jyoshi and Shakya 2017, Koops et al 2015) and serotonin syndrome (Ameen and Praharaj 2013). However, no cases were found in the literature describing occurrence in patients with neurocognitive disorder. Method: We present the case of a patient with neurocognitive disorder whose presentation included auditory functional hallucinations. We conducted a review of literature on functional hallucinations. Case Report: An 85-year-old male with no psychiatric history presented to the emergency room with a gradual decline in cognition. Delusions and auditory hallucinations were reported over the past 2 months. He reported hearing distressing voices of a little girl through the walls and over the hospital loudspeakers. His daughter reported that whenever the air conditioner or the radio was running at home, he would report hallucinations. He scored 19/30 on Montreal Cognitive Assessment with deficits in executive function, calculation, recall, and attention. CT and MRI showed global cerebral atrophy and subdural hygroma from recent head trauma 10 days back. EEG showed diffuse generalized slowing with no epileptiform focus. Labs, including TSH, B12, folate, and RPR, were unremarkable. He was diagnosed

with neurocognitive disorder and started on aripiprazole. Due to inadequate response, this was discontinued. Risperidone was started and titrated to 2 mg twice a day with complete resolution of auditory hallucinations. Discussion As the first case of functional hallucinations reported in association with neurocognitive disorder, this represents a novel etiology of functional hallucinations. Prior reports have described improvement in functional hallucinations with sodium valproate (Rajkumar 2012), ECT (Joshi and Shakya 2017), and transcranial direct current stimulation (Koops et al 2015). Our patient, however, had resolution of hallucinations with second generation antipsychotics. Conclusion: Functional hallucinations can occur with neurocognitive disorders and respond to second-generation antipsychotics. Further characterization of hallucinations in future reports may assist in obtaining a better understanding of this rarely-recognized condition. Additionally, it is unclear if functional hallucinations are a distinct entity or a form of illusory experience, given that both entail perceptual abnormalities with an external stimulus.

No. 2

Stress, Coping, and Strain in Family Members of Patients With Substance Use Disorder in India

Poster Presenter: Prabhuo Dayal

SUMMARY:

Background and aims: Family members are the primary caregivers of the patients with substance use disorder in many of the collectivistic societies. Living with a patient with substance use disorder imposes its own stresses and strain, and individuals use their own coping methods to deal with this stress. The Stress Strain Coping Support (SSCS) model has been developed to understand how certain coping styles mediate stress and stress. This study aimed to see the applicability of the SSCS model in an oriental developing country scenario. Methods: This cross sectional study included family members of patients seeking treatment at an addiction care facility. The participants were evaluated using Family Member Impact (FMI) scale for stress, the Symptom Rating Test (SRT) for strain, the Coping Questionnaire (CQ) for coping and the Hopefulness–Hopelessness (HOPE) scale. Multiple linear regression and hierarchical linear analysis

were used to assess the effect of stress on strain. Results: Thirty eight out of 89 recruited relatives were females. The primary substance among the patients was opioids, with a mean duration of substance use being 9.1 years. The mean total scores on FMI was 38.9 (± 8.5), SRT was 26.5 (± 12.8), CQ was 64.4 (± 13.5) and HOPE was 34.0 (± 5.4). On linear regression analysis, engaged coping was the only independent predictor for strain. Hierarchical linear regression suggested add-on effect on coping in explaining the relationship of stress and strain. Conclusion: SSCS model is applicable in collectivistic societies like India, though the types of coping that leads to experience of strain might be different from other regions due to differences in the societal characteristics.

No. 3

Potential Role of Neuroimaging Study in Supporting the Diagnosis of Alcohol Disorder With New-Onset Mood and Psychotic Symptoms

Poster Presenter: Obiora S. Nnaji, M.D.

Co-Author: Maria Chona Pili San Gabriel, M.D.

SUMMARY:

Background: Alcohol is a known etiology of structural and functional changes in the brain, including cerebellar atrophy. Elucidating alcohol use disorder as a cause of cerebellar atrophy is often difficult in the absence of historical or laboratory evidence. In this cases, supporting findings from imaging studies proves instrumental in arriving at the most accurate diagnosis and medical management. This is significant as there is evidence that alcohol-induced cerebellar dysfunction may improve with long-term abstinence. Case Presentation: We present a case of new onset depressive and psychotic symptoms in a patient with no previous psychiatric history adjudged to be due to alcohol use disorder. This is indicated by the lone finding of cerebellar atrophy in the setting of otherwise normal laboratory workup. Mr. A is a 67yo male brought in by EMS activated by mobile crisis unit (MCU) staff. He reported no past psychiatric treatment, with past medical history of hyperlipidemia, hypertension and degenerative disc disease (C6-8). He presented with acute manic symptoms including lability and hostility at work. He also manifested with persecutory delusions and

perseverated on playing the "Russian roulette" with his co-workers. He was disheveled with pressured speech, derailed thought process and suicide ideation. He provided inconsistent responses regarding substance use, notably for alcohol use, but admitted having drunk last on the day of presentation. Physical examination was within normal limits and on re-evaluation, was noted to manifest cerebellar signs (difficulty completing heel-to-shin test). Labs (CBC, LFT, BMP, TSH, RPR) were within normal limits. Given his alcohol use history BAL, GGT, urine drug screen, CDT were requested, all negative or within normal limits. Imaging studies (Head CT scan) was notable for cerebellar volume loss without other pathology. MOCA was 25/30, MMSE 30/30. Given his manifestations, he was subsequently admitted at the inpatient unit for further stabilization. He was started on risperidone and MV1/B1/Folate with good treatment response. He was offered medications to help curb ETOH use but refused. During his admission, he continue to minimize substance and alcohol use and declined consent for family to be contacted for collateral information. However, when explained of imaging studies and working impression, he was more forthcoming with substance use. Subsequently, patient was discharged with referral to outpatient chemical dependency clinical and motivational interviewing intervention. Conclusion: While psychiatric disorders are usually diagnosed on the basis of clinical manifestations as outlined in the DSM-5, diagnostic dilemma may arise if historical data is conflicting or limited. As in this case, imaging studies proved instrumental in the diagnosis, treatment and disposition planning, which may potentially provide significant long-term sobriety and improvement.

No. 4

WITHDRAWN

No. 5

Telepsychiatry-Assisted Follow Up Engagement of Treatment Dropout Substance Users

Poster Presenter: Raju Bhattarai

SUMMARY:

BACKGROUND Opioid Substitution Treatment (OST) is a harm reduction approach for Intravenous drug

users to shift them to oral Buprenorphine or Methadone. After a period, many of these clients drop out facing an increased likelihood of relapse. In such individuals a comprehensive approach right from the beginning of substance use treatment is essential. In India, OST is run by National AIDS Control Organization (NACO) and due to the nationwide shortage of mental health professionals, integrated treatment approach is unaccomplished in a majority of centers. Existing literature supports the role of economic methods such as telepsychiatry to facilitate mental health professionals' reaching out to substance-using clients. Brief intervention is useful in substance use population during different phases of drug treatment. Given the low psychiatrist/population ratio in India, telepsychiatry assisted brief intervention could be a viable alternative for the drop out population. By linking the psychiatrists to substance users in remote locations, tele-psychiatry could enhance treatment adherence and promote follow up. NACO counselor at every OST center regularly visits the non-adherent clients' homes to report the reasons of treatment drop out. Sixty client clients from the OST program at Gorakhpur, North India, who had the history of treatment drop out in preceding 3 months, were contacted through phone. Every week 10 clients were contacted and home visits were made to 4 willing clients in each week. Altogether, 32 clients consented for meeting over a period of 2 months. The meeting was conducted at home in presence of at least one family member as well as on a one to one basis. A 20 minutes session was conducted by the counselor. It began with detailing of the family members about the purpose of the visit, followed by obtaining an informed consent. Demographic details were noted and instructions were given for self-administration of 'Reason for Leaving Treatment Questionnaire' (RLTQ). After this, the facilitator connected the client to the psychiatrist through the medium of a tablet device for one to one brief intervention session. This was followed by the closure which included a group session with the client and the family members to address their queries. Clients were suggested to follow up at the OST center and restart the treatment at the earliest convenient date. The attendance frequency in the following 1 month after the telepsychiatry session was assessed and analyzed. RESULTS Twenty-eight

out of 32 clients approached the OST center within 3 days of the home visit session and 22 clients remained in treatment until 1 month period following the intervention. The most common reason for leaving the treatment was logistic problems. Twenty-nine clients were using some form of substance, alcohol being the most common; 18 reported to be using their substance of choice: heroin.

No. 6

An Exploratory Study of Drug Use Encounters by New York City Business Managers

Poster Presenter: Miranda Geniece Greiner, M.D., M.P.H.

Lead Author: Jonathan Avery

Co-Author: Alan Tomas Rodriguez Penney, M.D.

SUMMARY:

Background: Opioid-involved overdoses in the United States have dramatically increased in recent years, largely due to a rise in synthetic opioids. Illicitly manufactured fentanyl and other synthetics are often mixed with heroin, cocaine, street pills marked as "Xanax" and other substances--with or without the user's knowledge. Drug overdoses are occurring in broader settings than just business bathrooms with the rise in synthetics and counterfeit pills. Clubs and bars with recreational drug use are more vulnerable to public overdoses. Managers are often first-responders to drug overdoses by default, yet limited research has explored their experiences encountering drug use. This exploratory study examines the experiences by New York City business managers with drug encounters, paraphernalia, overdoses, and knowledge in overdose recognition and naloxone. Methods: A survey instrument modeled from a previously implemented survey collected data on manager encounters with drug use occurring in business settings. The survey explored business managers' encounters with drug use, paraphernalia, overdoses, activating emergency services for individuals, overdoses, and knowledge in overdose recognition and naloxone. Additionally, the survey gauged managers' perspectives on increasing accessibility to naloxone training and rescue kits, and if they encountered overdoses outside of business settings. Recruitment was guided by convenience

and purposive sampling. Results: This study is ongoing and preliminary results reveal that all managers interviewed had encountered drug use in their businesses, more than half (56%) of these managers found drug paraphernalia, and a third (31%) of managers found syringes. A vast majority (81%) of managers activated emergency medical services for a drug encounter and half (50%) after finding individuals unresponsive. Monthly encounters of drug use ranged from none to fifty with a mode and average of 10 encounters. Few managers (13%) had received overdose recognition or naloxone training. All managers shared mutual interest in naloxone being widely available to businesses. Conclusion: The preliminary results of this study indicate that local business managers in New York City are often encountering drug use and activating emergency medical services. There is a need for additional research and expanding overdose recognition and naloxone training to community stakeholders. Additional efforts must be considered amongst national-level stakeholders to combat the opioid crisis such as improved availability of naloxone rescue kits, test strips to detect synthetic opioids in substances, supervised injection facilities, drug consumption rooms, and other interventions reducing the high rates of overdose deaths.

No. 7

Building a Novel Psychiatry Resident Asylum Clinic: Responding to the Refugee Crisis and Enhancing Resident Training

Poster Presenter: Alpna A. Agrawal, M.D., Ph.D., M.P.H.

Co-Authors: Roya Ijadi-Maghssoodi, M.D., Sonya Gabrielian, M.D., M.P.H.

SUMMARY:

Background: In the United States, immigrants seek asylum based on fear of harm due to race, religion, nationality, political opinion or membership in a “particular social group.” In 2017, an all-time high of 16,331 asylum applications were filed. Psychiatric evaluations are instrumental in asylum cases, supporting asylum seekers’ experience of persecution in their home countries. Few studies have described effective processes to engage psychiatry trainees in these efforts. Study

Objectives: In 2018, in response to the need for mental health evaluations for asylum-seekers, and growing interest among psychiatry trainees in conducting forensic asylum evaluations, the UCLA Department of Psychiatry—in conjunction with the UCLA David Geffen School of Medicine—established an asylum clinic elective for psychiatry residents. Coined the “Los Angeles Human Rights Initiative Asylum Clinic,” the clinic will be offered in the 2019-2020 academic year for the first time. The proposed quality improvement study aims to (1) describe the development of an asylum clinic for psychiatry trainees at a major academic institution and (2) evaluate its impact on resident training. Methods: We will use mixed methods to address the study aims. To capture the clinic’s development (aim 1), we will collect field notes from participating residents and key informant interviews with mental health professionals and legal advocates leading similar initiatives at other institutions. These qualitative data will be collected and analyzed thematically to describe the clinic’s implementation. To evaluate the clinic’s impact on resident training (aim 2), we will administer surveys to psychiatry residents in the clinic at multiple time points during the 2019-2020 academic year. The surveys will assess the clinic’s impact on residents’ clinical skills in the domains of PTSD and other trauma-related psychiatric conditions, as well as on cultural competency. The educational value of the clinic’s curriculum (e.g., journal clubs, therapeutic support group, supervision, and didactics) will also be assessed. We will use descriptive statistics to capture change in these domains over time. Conclusions: In the midst of the current global refugee crisis, despite the benefit of psychiatric evaluations to asylum-seeker’s cases, and a growing interest in global mental health among trainees, little is known about processes needed to develop effective asylum clinics for psychiatry trainees. This quality improvement study aims to help other academic institutions build capacity in asylum evaluations for an under-resourced group, while furthering psychiatric training at the intersections of global health and human rights, the legal system, and psychiatric disorders.

No. 8

Breaking the Taboo: When Politics Enters the Professional Realm: A Curriculum

*Poster Presenter: Madeleine S. Abrams, L.C.S.W.
Co-Author: Esther Devorah Rollhaus, M.D.*

SUMMARY:

It has become increasingly difficult to separate world events and the realm of politics from our clinical work with poor, minority, and immigrant populations in the Bronx. For therapists to express their personal viewpoints about such issues as race, religion, gender, and immigration to their patients has traditionally been prohibited. However, we believe that it is impossible to ignore the interconnection between the clinical and the political; in fact not taking a stand may in fact be taking a stand. Although the proscription about discussing controversial issues with patients and even among peers and students exists, in light of current polarizing ideologies a failure to acknowledge important issues in a thoughtful way may, in fact, diminish trust and safety. Thus, in order to promote health equity, we believe that dialogues between faculty, staff, and students are important in order to facilitate advocacy for those in our care. We hypothesize that if we are able to talk to each other and clarify our own ideas, we will be better able to ally with consumers in their quest for just and appropriate mental healthcare. To that end, we have designed a curriculum composed of readings experiential exercises, case vignettes, and videotapes that are designed to promote discussions of complex social issues. In this poster, we will present our curriculum for engaging residents in discourses about social justice issues and the results of a survey administered to trainees in our program. Examples of ethical clinical and systems issues with which we have been confronted will be included. • Decision to discharge someone from confinement when he/she risks deportation if in the community • Psychotic episode following trauma of violent incident of racial profiling • Once a person has been defined and treated in a certain way, that view becomes fixed even if he/she has changed and improved

No. 9

Addressing Disparities: A Residency Didactic Curriculum Examining Processes That Led to Disparate Mental Health Outcomes

*Poster Presenter: Angela Anita Coombs, M.D.
Co-Author: Roberto Lewis-Fernández, M.D.*

SUMMARY:

As mental health disparities facing racial/ethnic, gender and sexual minorities persist, we propose that not including education and training about the mechanisms of inequity only make it all the more challenging for the next generation of psychiatrists leaving training to address them. We, a resident and a faculty member, developed a 6-session curriculum for the PGY3 class that examines the major processes that lead to disparate mental health outcomes. These processes fall chiefly into three categories from which we structure the course: society level (e.g. social determinants of health; structural inequalities), institutional level (e.g. diagnostic and treatment limitations; workforce diversity) and individual level (e.g. unexamined bias, both explicit and implicit). We outline the major points of each session. By the end of this course, 100% of participants (n=10) identified that the course overall improved their understanding of how various processes lead to disparities in mental health outcomes among different minority populations. Participants identified advantages of have a course organized by both a co-resident and a faculty member. These advantages included believing that a co-resident has a good understanding of their peers needs and interests as learners as well as helps with engagement by creating greater buy-in. Limitations of our course include its limited number of sessions and thus limited number of "case studies" or examples involving many more populations (e.g. Asian American immigrants). However, we believe that the strength of specifically examining processes that lead to disparities as opposed to only the disparities themselves allows learners to critically analyze possible mechanisms at work for a variety of populations not explicitly discussed within the course. Lastly, while we acknowledge the utility of having a course organized by a resident and faculty member, we believe it is important to not that trainees, and perhaps especially those from traditionally underrepresented groups, are vulnerable to burn out and it is important to be

mindful of placing additional training burdens on them.

No. 10

A Longitudinal Study of Psychiatry Residents' Perspectives of Primary Care

Poster Presenter: Bianca T. Nguyen, M.D., M.P.H.

Co-Authors: Claudine Elaine Jones-Bourne, M.D.,

Melissa Arbuckle, M.D., Ph.D.

SUMMARY:

Background: Comorbid medical issues and limited access to high-quality health care contribute to the increased risk of mortality among patients with mental illness. Addressing primary care issues in behavioral health care settings may reduce such disparities. We undertook this study to better understand psychiatry resident perspectives regarding their role in treating general medical conditions in psychiatric patient populations in their future practice and how these perspectives might evolve over the course of training. Methods: Between July and October 2017, all 46 adult psychiatry residents at Columbia University Medical Center were asked to complete an online survey which asked them to rate their ability, interest, and comfort in managing the general medical conditions of their psychiatric patients. We compared responses between PGY1, 2, 3, and 4 residents across each of these domains. Since the PGY1 resident responses were notably different from their peers, we resurveyed this cohort a year later (in October 2018) as PGY2s in order to determine if their opinions changed. Results: Sixty-seven percent of residents responded to the initial study. Most residents (81%) indicated they were knowledgeable and/or comfortable in managing medical conditions with supervision/consultation from a primary care provider. There were notable differences in resident opinions on whether they would like to independently manage the general medical conditions of their patients and whether or not they should be able to do so in the future. Seventy-one percent of PGY1s indicated that they would like to independently manage both behavioral and general medical conditions of their patients (i.e. without the supervision and consultation of a primary care provider), compared to only 9% of PGY2s, 14% of PGY3s and 17% of PGY4s. Similarly, 86% of PGY1s

felt that they should be able to do so in the future compared to only 9% of PGY2s, 0% of PGY3s and 17% of PGY4s. When this PGY1 cohort was surveyed a year later (now as PGY2s), their attitudes changed substantially with none indicating that they "should be able to" independently manage both behavioral and medical conditions and only 10% indicating that they "would like to" do so in the future. Nicotine dependence and dyslipidemias were among the top conditions residents felt they should be able to manage (>74%). A lack of knowledge, experience, training, and supervision were the most frequent barriers residents listed in providing general medical care to patients. Conclusion: These results indicate that residents desire and expect to manage general medical conditions of their psychiatric patients in the future, and that the degree to which they feel they can do so independently changes over the course of training. Our study suggests that attitudes and plans for future practice differ based on PGY-level. Future studies could explore how these results might compare with psychiatrists in practice.

No. 11

A Narrative Review of Mood Disorders in Indian Cinema

Poster Presenter: Harsh Patolia

Co-Author: Badr Ratnakaran, M.B.B.S.

SUMMARY:

Introduction: Cinema is a visual medium that can depict psychiatric disorders such as Dissociative Identity Disorder. They can help introduce and give the general population a better understanding of mental illness. Here we review films portraying depression and bipolar disorder in Indian Cinema. Method: Films were identified after discussion with various experts in person, web sources and email correspondence Results: 28 films portraying lead characters with bipolar disorder and depression were identified. They characters range from different age groups and gender with balanced and unbalanced portrayal. Various related themes including grief, trauma, alcoholism, suicide ideation have been portrayed. Conclusion: The portrayal of Dissociative Identity Disorder in the films in our study can be used to better understand how Indian films characterize this disorder.

No. 12

A Meta-Analysis of Noninvasive Brain Stimulation for Schizophrenia

Poster Presenter: *Kaevon Brasfield*

Co-Author: *Alexander Chen*

SUMMARY:

Background: Prior studies have suggested that transcranial magnetic stimulation (TMS) and direct current stimulation (DCS) may have benefits in treating schizophrenia, however, the data has been conflicting and multiple new trials have been published since the latest reviews. Our study aims to provide a comprehensive and updated review of the efficacy of adjunctive TMS and DCS in the management of psychosis and to determine the optimal treatment parameters for these neuromodulatory therapies. Methods: An online search was conducted through PubMed, Google Scholar, and ClinicalTrials.gov for randomized controlled trials of TMS and DCS for schizophrenia. Meta-analysis was conducted with calculated mean weighted effect sizes (Cohen's *d*). Heterogeneity was measured using Cochran's *q* and *I*². Results: 49 TMS studies and 10 DCS studies met criteria for inclusion. TMS treatment demonstrated significant reductions of PANSS total ($d = -0.193$, $p = .016^*$), PANSS negative ($d = -0.251$, $p = .001$), AHRs ($d = -0.533$, $p < .001^*$), and CGI ($d = -0.450$, $p < .001$) scores but no significant changes to PANSS positive ($d = -0.020$, $p = .760$) score. DCS treatment demonstrated significant reductions of PANSS negative ($d = -0.251$, $p < .001$) and AHRs ($d = -0.483$, $p = 0.045$) scores, but not PANSS total ($d = -0.137$, $p = 0.493$) or PANSS positive ($d = 0.025$, $p = 0.901$) scores. Sub-group analyses of the TMS studies to assess for potential moderators of effect including location of stimulation, frequency, and total stimulation received were also performed. Upon comparing studies by location of stimulation, analysis of studies that only stimulated the dorsal lateral prefrontal cortex (DLPFC) continued to show a significant benefit in reducing PANSS negative ($d = -0.329$) and PANSS total ($d = -0.230$) scores, but analysis of studies that only stimulated the auditory cortex (T3P3) did not demonstrate significant changes between treatment and sham groups. When comparing stimulation frequency, 1hz showed no significant differences between treatment and sham; 10hz showed significant

reductions in both PANSS negative ($d = -0.506$) and PANSS total ($d = -0.251$) scores; 20hz showed significant reductions in PANSS positive ($d = -0.514$), PANSS negative ($d = -0.424$), and PANSS total ($d = -0.626$) scores; and theta burst stimulation showed significant reductions in PANSS Negative ($d = -1.076$) and PANSS Total ($d = -0.770$) scores. Additionally, we found a positive correlation between total stimulation received and the magnitude of symptoms score changes compared to sham. Conclusion: The data suggest that TMS and DCS may have efficacy in treating the negative symptoms and auditory hallucinations of schizophrenia. Setting parameters for high frequency, long-term stimulation, targeting the DLPFC seem to maximize efficacy in reducing symptom scores. Future large scale prospective trials are warranted to verify the results and to further explore the mechanisms of action involved

No. 13

A Rare Psychotic Aura: Delusions of Persecution Associated With Migraine

Poster Presenter: *Praveen A. Walaliyadda*

Co-Author: *Samuel Oliver Sostre, M.D.*

SUMMARY:

Purpose: The sudden emergence of psychotic symptoms in any patient with no psychiatric history should prompt a search for secondary causes. Migraine is a common condition and several case reports documenting psychotic symptoms associated with the aura of migraine have been published. Methods: We present a case of suspected psychosis and suicide attempt associated with migraine. Results: 57 year-old female with no personal or family history of psychiatric disorder presented for evaluation after suicide attempt via overdose. Her spouse reported that she had been in her usual state of health until 2 days prior to the ingestion when she noticed the patient to be concerned that co-workers and neighbors were talking about her, her phone was being bugged, and that she was being followed while driving. On examination, she reported a history of migraine previously diagnosed and treated by a neurologist. 2 days prior to her suicide attempt, she began to experience her usual headache characterized as a unilateral, throbbing headache. She recalled feeling that someone in a car outside of

her home was following her but had no subjective or objective evidence of continuous psychosis or that she was experiencing an acute affective state. Neuroimaging and laboratory work-up were normal. She was admitted psychiatrically due to the suicide attempt and observed for the recurrence of psychotic symptoms. During a 4 day hospitalization, she had no further psychotic symptoms or suicidal thoughts. Conclusions: Migraine is a common condition affecting approximately 12% of the population in Western countries. Migraine often includes an aura, a transient focal neurological phenomenon that occurs before or during the headache. The mechanism for the development of the aura is linked to cortical spreading depression, a self-propagating wave or neuronal and glial depolarization that spreads across the cerebral cortex. The symptoms present during the aura are believed to depend of the cortical areas involved. Visual phenomena are common but may also include higher mental functions including the emergence of hallucinations, delusions, and suicide attempts. This current case report hopes to add to the literature and to make psychiatrists aware of this common neurological condition should be included in the differential diagnosis of transient psychosis. Objective 1: Understand the mechanism of migraine aura Objective 2: Be aware of rare psychotic aura Objective 3: Understand the need to search for secondary causes of psychiatric symptoms in patient with an atypical presentation Relevance: Migraine is a common condition. Psychiatrists must be aware of possible psychotic symptoms preceding and during migraine.

No. 14

“Let Me Out!”: Anti-NMDAR Encephalitis on the Psychiatric Wards—a Case for Routine Screening in First-Episode Psychosis

Poster Presenter: Bora Colak, M.D., M.P.H.

Co-Authors: Hande Okan, M.D., Ariel Heller, D.O., Mohammad Tavakkoli, M.D., M.P.H., M.Sc., Reena Baharani, M.D.

SUMMARY:

The discovery of Anti-NMDAR encephalitis is little over a decade old. Early research shows that a majority of cases initially present with psychiatric symptoms, often leading to misdiagnosis as a

primary psychotic disorder. Many of these cases do not have clear neurological signs until later in the disease course, often delaying prompt diagnosis and treatment and significantly increasing morbidity and mortality. Initial studies suggest that there is a critical window for treatment, beyond which patients may have irreversible neurological sequelae. Moreover, anti-NMDAR encephalitis is much more common than initially thought, and some cases of chronic schizophrenia may even be attributed to autoimmune insults which have progressed over time. Preliminary studies show that screening the first episode psychosis (FEP) population leads to earlier diagnosis and better long-term outcomes. Routine screening in FEP patients may be indicated to reduce the burden of this increasingly observed disease entity. We present a case of a highly functional, independent, and educated 26 year old male with no significant medical history, psychiatric history of ADHD as a child, who presented to the psychiatric ER with disorganization and agitation. The patient was subsequently hospitalized on the inpatient psychiatric ward and had a protracted course on the inpatient wards with poor response to antipsychotic treatment. Cognitive changes such as short-term memory loss, changes in his speech, and waxing and waning of cognition were observed, but neurological workup was delayed due to the patient’s extreme level of agitation and frequent attempts at elopement. Five weeks after his initial presentation, the patient was diagnosed with and treated for anti-NMDAR encephalitis. The patient’s response to treatment was initially slow but at two months following treatment he appears to have returned to his baseline. Despite the apparent recovery, the patient’s response time to treatment was relatively poor, and the delay in diagnosis and involuntary confinement to the psychiatric unit resulted in severe emotional turmoil for both the patient and family. An early screening protocol would have provided the opportunity for prompt detection of the condition, minimized the risk of permanent sequelae, and significantly diminished unnecessary distress to patient and family. In addition to emphasizing the importance of having a high index of suspicion for autoimmune etiology in cases of first episode psychosis, this case adds to a growing body

of reports which point to the need for routine screening in this population

No. 15

Developing a Correctional Psychiatry Curriculum for Residents

Poster Presenter: Meghan Musselman, M.D.

Co-Authors: Jose Hidalgo, David Louis Beckmann, M.D., M.P.H., Allison Brandt, M.D., Sarah A. MacLaurin, Andrew Stephen Cruz, M.D., Oliver Freudenreich, M.D., Derri Lynn Shtasel, M.D.

SUMMARY:

With the passage of the Community Mental Health Act in 1963, efforts began to decrease the number of active beds in long-term stay state psychiatric facilities and instead promote community mental health services. Unfortunately, as state psychiatric beds closed, the number of inmates in jails and prisons with serious mental illness rose, in a process sometimes referred to as “transinstitutionalization.” It is now estimated that more than half of all persons experiencing incarceration meet criteria for having a mental illness. Prevalence rates of serious mental illness (SMI) jails are estimated to be 3 to 6 times the rate in the general population. In order to respond to the criminalization of mental illness, a more robust pipeline of psychiatrists with comfort in the correctional setting is necessary. Despite the clear need for psychiatric treatment in correctional settings and the breadth of educational opportunities these settings offer, few psychiatry residency programs feature rotations in correctional settings. When correctional rotations are offered, they are typically elective, exposing an estimated 50% of residents at these programs to the correctional setting. Minimal exposure in residency training has the downstream effect of generating a workforce ill-equipped to treat this growing, complex population. To address this need, we developed a comprehensive correctional psychiatry curriculum as a way for residency programs, including our own, to introduce psychiatry residents to the intricacies of working in the correctional setting. In this poster, we discuss the rationale for psychiatry residency programs to have exposure to the correctional setting, the key components of a correctional psychiatry rotation and curriculum, and models in which trainees at other levels (e.g. medical

students, public psychiatry fellows) may get exposure to this increasingly important psychiatric setting.

No. 16

Tomorrow’s Innovators: Analyzing Trends of U.S. Osteopathic Medical Students Matching Into Psychiatry Using 2014–18 National Resident Match Program Data

Poster Presenter: Amanda B. Seamon

Co-Authors: Ayesha Khan, Maria A. Grullon, Robert Osterman Cotes, M.D.

SUMMARY:

Residency programs in all specialties are seeing an increasing number of graduates from osteopathic medical schools apply and successfully match in their programs. The number of graduates from osteopathic medical schools participating in the National Resident Matching Project (NRMP) went from 2,738 in 2014 to 4,617 in 2018, a 69% increase. Over that same time period, US seniors from allopathic medical schools only increased by 8%. Of the total number of successfully matched residents over 2014-2018, 7.3% of osteopathic residents matched into psychiatry versus only 4.9% of allopathic residents. Over the past five years, osteopathic students are making up a greater proportion of the total number of psychiatry PGY-1 slots, with 11.5% in 2014, increasing to 15.6% by 2018(1,2). Using NRMP data from 2014-2018, we found significant state by state variation in matched osteopathic students in psychiatry. The states that had the highest proportion of osteopathic residents were Nevada (59.7%), Arizona (42.7%), Kansas (35.4%), Alabama (29.2%), Iowa (27.1%), and Ohio (27.0%). The states or territories with the lowest proportion of osteopathic residents were Puerto Rico, Rhode Island, and Vermont, each of which had no osteopathic residents matching over the five year period. In the poster format, we will present a graphic of the US which color codes each state by the percentage of matching osteopathic students (first quartile >19.5%, second quartile 19.4-13%, third quartile 12.9-8.6%, fourth quartile < 8.6%). To better understand factors contributing to this variation, we hypothesized that states with an established osteopathic school would have more osteopathic residents matching into that state. We

found that in each year, the average percentage of psychiatry residency slots filled by osteopathic medical graduates was, in fact, higher in states containing an osteopathic medical school. In 2014, the average percentage of psychiatry residency slots filled by osteopathic medical graduates in states with an established osteopathic medical school was 15.2%, and this number increased to 20.1% by 2018. In contrast, the average percentage of psychiatry residency slots filled by osteopathic medical graduates in states without osteopathic medical schools which was 10.1% in 2014 increasing to only 13.2% in 2018. This data supports the idea that psychiatry residency programs in states more familiar with osteopathic teaching are more likely to recruit osteopathic medical school graduates to their psychiatry residency programs. In conclusion, the trends and data presented here can be used by third and fourth year osteopathic medical students looking to apply to a psychiatry residency program in the US. The residency application process can be daunting with so many programs to consider and so many variables to weigh in the decision-making process. Applicants could use this information to optimize their time and money when visiting programs.

No. 17

Antipsychotics, Pregnancy, and Safety?

Poster Presenter: Simrat Sarai

Co-Author: Tejaswini Doifode

SUMMARY:

Mental health illnesses prevalence is about 25% in American adults. Roughly 21% to 33% of pregnant females are prescribed antipsychotic (AP) agents. There is a 50% or more risk of relapse of bipolar and psychotic disorders during pregnancy and the immediate postpartum period. Since 2015, the Pregnancy and Lactation Labeling Final Rule require a label to include more details about the harmful effects of the medication on mother and unborn baby in place of pregnancy letter categories. As always the risk vs benefit of APs should be carefully taken into consideration.

No. 18

A Multidisciplinary, Mother-Baby Approach to the Treatment of Postpartum Psychosis

Poster Presenter: Madeline Tivon

Co-Author: Sarah Homitsky, M.D.

SUMMARY:

Mrs. H, a 36-year-old married mother of two children with a history of depression presented to an outpatient psychiatrist two weeks after the birth of her second child. She reported sleep disturbance and trouble concentrating, and her partner was concerned about suicidal thoughts, auditory hallucinations and delusional thinking surrounding her breastmilk. Following a diagnosis of postpartum psychosis, Mrs. H agreed to begin olanzapine 5mg nightly. The patient improved substantially, returning to work at three months postpartum. However, a month later, the patient's mood declined and bipolar disorder was suspected. Though further medication adjustments were attempted, the patient continued to deteriorate, attempted suicide, and was involuntarily hospitalized. During the hospitalization, she was started on Lithium 600mg nightly. After her release from the hospital, Mrs. H remained uncooperative with medication, tore up her crisis plan, and repeatedly attempted to walk into traffic. Her psychiatrist strongly recommended inpatient care. Instead, Mrs. H enrolled in an intensive outpatient program (IOP) specializing in reproductive health. As part of the multidisciplinary program, she and her infant attended group therapy with other postpartum mothers, as well as weekly individual therapy and medication management. The intensive outpatient setting prevented disruption of the mother-infant dyad, allowing for bonding in a supervised environment with access to essential mental health treatment. Over the course of the program, significant improvement was noted in the patient's EPDS, PBQ, and GAD-7 scores. After three weeks in the IOP, Mrs. H and her family agreed that she had achieved her baseline mood and level of functioning and she was able to return to outpatient care. This case illustrates the value of a reproductive health-focused approach to the treatment of postpartum psychosis.

No. 19

Impact of Prolonged Psychiatric Hospitalization on the Disease Course of Borderline Personality Disorder Patients

Poster Presenter: Ahmad Rehan Khan, M.D.

*Co-Authors: Saad Wasiaq, Hafsa Mahmood, M.B.B.S.,
Saher Kamil, Hina Saeed, Amber Ehsan Faquih*

SUMMARY:

Borderline Personality Disorder (BPD) is one of the most common personality disorders, characterized by a pattern of unstable mood, behavior, self-image, and functioning. A person with BPD may experience mood swings, pattern of unstable relationships, fear of abandonment, chronic feelings of emptiness, and suicidal behavior and self-mutilation. The prevalence of BPD varies from 0.5-1.4% in the total population. Its pathophysiology is not well understood but genetic factors, brain abnormalities, and stressful life events may play a role, with a rather unstable course of illness as compared to other personality disorders. It is not uncommon for individuals with BPD to present with other mental health disorders such as mood, anxiety, and substance use disorders. BPD is typically diagnosed by psychiatric interview and often psychological testing like MMPI- 2 is used. The most effective treatment is Dialectical Behavioral Therapy with the role of pharmacotherapy being controversial. Back in the days, prolonged hospitalization was the only mode of treatment for BPD patients. Now a day's inpatient psychiatric hospitalization is discouraged and is an option for only those BPD patients not responding to conventional treatment or have persistent active suicidal ideations. We present a case of 47-year-old female, carrying a diagnosis of BPD, with no other psychiatric comorbidity. The patient has been receiving treatment for BPD for the past 25 years. She was in and out of state hospital from ages of from the ages of 30 to 39. For the past 8 years, she remains admitted to the Adult Inpatient Psychiatric floor at the state hospital. Whenever her mood dysregulation improves and she reaches closer to discharge, she self-sabotages it by being violent. Due to her prolonged hospital stay, it seems that she has developed 'institutional syndrome'. We present this case to demonstrate an association of BPD and prolonged inpatient psychiatric hospitalization leading to institutional syndrome.

No. 20

Examining and Measuring Sources of Stress in a Sample of Caregivers of Children With Special

Needs in Egypt: The Perception of Caregivers Stress Scale

Poster Presenter: Dalia Bedewy

SUMMARY:

The purpose of this study is to examine stress among caregivers of multiple handicapped children, and to develop and psychometrically assess an instrument to measure the sources of psychological stress among caregivers. Following empirical evidence and recent literature review the researcher developed a 24-item scale to measure the sources of stress among caregivers with (6 – 18) years old children with mental and physical handicap. Experts (n=12) participated in a formal validation process of the instrument before it was administered to (n = 209) both male and female caregivers who are directly involved in the daily care of their handicapped children. Internal consistency reliability for the instrument was .86 (Cronbach's alpha) and there was 89% overall agreement between experts about the relevance of the instruments' items to measure caregivers perceptions of sources of stress related to the care of their children, providing evidence for content validity. Factor analysis resulted in four cohesive and theoretically meaningful factors. There is evidence for content and convergent validity. The developed instrument is a reliable, valid and empirical measure to assess the severity of stress. The scale will take ten minutes to complete.

No. 21

Medical Student Stress in Wuhan, China: Sources, Outcomes, and Solutions

Poster Presenter: Alison Kilcup

Lead Author: Margaret Z. Wang, M.D.

Co-Authors: Kunmi Sobowale, M.D., Rui-Mei Feng, Jingyi Fan, M.D.

SUMMARY:

BACKGROUND: Globally, physician depression and burnout rates have been shown to be higher than both the general population and peers in other academic fields. They are particularly striking in China, where 65% of physicians report depressive symptoms, a rate much higher than other countries. This trend appears to begin during medical training; a recent study on Chinese medical students showed 13.5% of students endorsing symptoms of

moderate-severe depression, with a third of depressed students endorsing suicidal ideation. This paper aims to identify the sources and severity of stressors in Chinese medical students, and their relationship to depressive symptoms. **METHODS:** Fourth and fifth year medical students (N=168) at one medical school in mainland China completed a 27-item questionnaire evaluating the frequency and severity of various sources of stress. Students were also asked to complete the Perceived Stress Scale 10 (PSS-10) to evaluate individual appraisal of stress, as well as the PHQ-9. Mean PSS-10 scores for students were obtained for the sources and severity of stressors, as well as for various demographic factors. Stress outcomes, measured by PHQ-9, included depression, suicidal ideation, and impairment. The association between each stressor category (academic, career, psychosocial, or health-related) and stress outcome was assessed using logistic regression after adjustment for sex, family income, and number of siblings. **RESULTS:** A total of 168 students were surveyed. One hundred and sixty-two (99.4%) students reported 'less than often' for academic stressors, 145 (87.9%) reported 'less than often' for career stressors, 102 (62.9) reported 'less than often' for psychosocial stressors, and 117 (70.9) reported 'less than often' for health-related stressors. The mean PHQ-9 score was 7.1 (SD = 4.5). Seventy-four (46%) of respondents had scores reflective of mild depression, 32 (20%) of moderate depression, and 8 (5%) of severe depression. Students who had scores in the third quartile for academic stress and those in the highest quartile for career stress has significantly higher PHQ-9 scores than those with lower stress. Significant increases in impairment were found with increased frequency of stressors in all categories. No correlation was seen between suicidality and stress. **CONCLUSIONS:** This study is the first to identify sources of stress in Chinese medical students and their relationship to psychiatric morbidity. We have found a significant relationship between increased frequency of stressors, depression, and impairment. Wellness curricula and mental health services are not generally offered by Chinese medical schools; by identifying the most common stressors, we have identified areas that may be addressed by medical school administration in order to improve mental health in this population.

No. 22
WITHDRAWN

No. 23
When Death Is Preferred: Creating a Curriculum and a Framework for Psychiatry Residents to Explore Patient Requests for Hastened Death

Poster Presenter: Carolyn Certo Gnerre, M.D.
Co-Author: Naalla D. Schreiber, M.D.

SUMMARY:

The American Medical Association and the American Psychiatric Association do not recognize rational suicide or physician assisted suicide (PAS) as medical options for end of life treatment. In contrast to our professional organizations, there is a growing movement nationwide to legalize PAS and to consider patient requests for rational suicide as within the realm of legitimate options for end of life care. Medical students, residents, and physicians need to be educated on how to address patient requests for hastened death. In particular, trainees should learn to openly discuss these issues with their patients to provide comprehensive end of life care yet stay within appropriate legal and ethical boundaries. We have implemented a case-based 3-hour curriculum during the PGY-3 year of residency at Montefiore Medical Center to address the different means by which patients may pursue hastened death. This discussion and lecture series is case based, using scenarios from both our institution and national news to highlight key teaching points. The curriculum includes education on the differentiation of treatment refusal from suicide. The curriculum also covers an exploration of decisional capacity and the potential conflicts between patient autonomy and beneficence. Furthermore, there is an in-depth exploration of the practical and ethical differences between suicide, rational suicide, PAS, and euthanasia. In order to investigate the efficacy of the curriculum, we performed a survey over three academic years to explore resident knowledge about and attitudes towards hastened death, which was administered before and after this educational series. The survey demonstrated that this teaching intervention was successful in helping residents to understand the basic definitions of the various forms of hastened death and to become more comfortable

discussing issues of hastened death. We expect that discussing requests for hastened death with patients will only become more common as societal values continue to shift towards greater personal autonomy at the end of life, including the right to die. The implementation of an educational program for psychiatry trainees that focuses on how psychiatrists can understand and address requests for hastened death is essential to producing psychiatrists adept at managing these requests. Our informal survey demonstrates that a lecture series at our institution has proven to be an effective first step in helping trainees understand and process these requests with their patients. It is important for trainees to be exposed to as many ethically complex scenarios as possible during residency to prepare them for the complexities of becoming an independent practitioner. This knowledge is crucial for compassionate patient care and is essential to facilitate an ongoing and productive dialogue among physicians about patient's rights to hastened death.

Presidential Sessions

Friday, October 04, 2019

A State Mental Health System's Embrace of Wellness, Prevention, and the Social Determinants of Health

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

Presenters: Ann Marie T. Sullivan, M.D., Merrill Rotter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Differentiate between promoting wellness, primary prevention, early detection, and early intervention; 2) List five social determinants of mental health, along with strategies for addressing them; and 3) Describe the New York State Prevention Agenda and opportunities for cross-agency collaboration.

SUMMARY:

State mental health authorities are responsible for both licensing and regulating community-based mental health programs, and operating state psychiatric hospitals and affiliated services. Such programs focus almost exclusively on providing

mental health care services (i.e., treatment, or tertiary prevention) to individuals with existing mental illnesses; in the case of state hospitals, individuals with the most serious and impairing illnesses. Nonetheless, state mental health agencies commonly also have a mission to advance the prevention of behavioral health conditions, including early detection and early intervention initiatives, as well as identifying opportunities to address structural and social determinants that predispose to behavioral health disorders. This session will describe some of the efforts of the New York State Office of Mental Health (OMH) in the areas of wellness, prevention, and addressing the social determinants of health. With regard to early detection and intervention, for example, OMH funds Project TEACH, which provides rapid consultation, education and training, and referral/linkage services to pediatric primary care providers (PCPs). OMH also facilitated the expansion of a statewide network of Coordinated Specialty Care programs for first-episode psychosis (OnTrackNY), which helps adolescents and young adults with early-course psychotic disorders achieve their goals for school, work, and relationships. With regard to wellness, many of the counties and agencies funded by OMH incorporate community-based wellness activities into their programming. Promoting mental health and well-being are also stated goals in the New York State Prevention Agenda. In terms of primary prevention, OMH funds the expansion of Healthy Steps, an evidence-based, interdisciplinary pediatric primary care program that promotes positive parenting and healthy development for babies and toddlers, with an emphasis on families living in low-income communities. OMH is also working to emphasize the importance of, and address, the social determinants of mental health, and the social determinants of adverse health outcomes among individuals living with serious mental illnesses. Efforts in this area include establishing an internal working group focusing on the social determinants, participating with many other state agencies in the New York State Prevention Agenda and the Governor's Health Across All Policies initiative, and collaborating with other state agencies on screening and intervention for social determinants, including, for example, food insecurity. Presenters will, in turn, describe these efforts, programs and initiatives,

focusing on how they fit into the key role the state's Office of Mental Health can play in driving a wellness agenda at both clinical and systems/structural levels.

BEDLAM: A New PBS Film and Book on America's Mental Illness Crisis

Chair: Kenneth Paul Rosenberg, M.D.

Presenter: Kenneth Paul Rosenberg, M.D.

Discussants: Patrick J. Kennedy, Adrienne Kennedy, M.A., Bruce Jan Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To share public education efforts to reduce stigma and create a call to action; 2) To share public education efforts to reduce stigma and create a call to action; 3) Public and professional education to understand deinstitutionalization; 4) Promote a discussion of the criminalization of the mentally ill and the role of advocacy in creating change; and 5) Promote discussion about how to address America's crisis in psychiatric care for people with serious mental illness.

SUMMARY:

After the death of his sister who was diagnosed with schizophrenia, psychiatrist Kenneth Rosenberg takes on the role of filmmaker and author to examine a national health crisis and the poignant stories of people grappling with schizophrenia, bipolar disorder and other chronic psychiatric conditions. Their symptoms shove them into the path of police officers, ER doctors and nurses, lawyers and prison guards. Shot over the course of five years, Rosenberg takes us inside Los Angeles County's psych emergency department, a nearby jail warehousing thousands of psychiatric patients and the homes — and homeless encampments — of people suffering from severe mental illness, where silence and shame often worsen the suffering. In this session, Dr. Rosenberg will present a sneak preview of clips from his upcoming PBS Health Initiative documentary which premiered at the 2019 Sundance Film Festival and will be broadcast on the PBS Independent Lens series in the spring, 2020 in a discussion with APA President Bruce Schwartz, MD.

Critical Issues in the Assessment and Treatment of Suicidal Physicians

Chairs: Michael F. Myers, M.D., Peter M. Yellowlees, M.D.

Presenters: Joan Anzia, M.D., Carla Fine

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) Appreciate the importance of enlisting survivors of physician suicide loss in prevention efforts.

SUMMARY:

It has long been known that treating symptomatic physicians is a complicated business and far too often ailing doctors do not get the same standard of care that lay patients receive. When the physician is suicidal the consequences can be dire. New and creative approaches to understanding the drivers of physician suicide and implementing life-saving interventions are essential. This session combines the perspectives and experiences of three senior psychiatrists who have been training, assessing and treating physicians throughout their decades-long careers. It also includes the postvention perspective of a survivor of physician suicide loss, a writer, activist and international speaker. Dr Peter 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. Dr Joan Anzia, a residency program director and physician health liaison for a large academic medical center, will describe especially challenging nodal points in

physicians' career lives, the deep personal impact of particular stressors such as adverse clinical events, and aspects of the implicit culture of medicine that can contribute to distress. She will also address the difficulties of changing a longstanding culture as well as potential systems approaches that could promote positive changes. Dr Michael Myers, concentrating on his qualitative research on families (and significant others) 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 feelings of exclusion these individuals have felt by their loved one's caregivers; and survivors' commitment to advocacy. Ms Carla Fine lost her husband Dr. Harry Reiss, a 43-year-old urologist, to suicide in 1989. She will describe how the mourning process following the suicide of a physician is defined by silence and confusion for those who are left behind. She will offer practical suggestions for treating survivors of suicide loss and engaging in collaborative work to prevent more physician suicides.

Improving the Care and Outcomes of Individuals With Early Psychosis: A Focus on Reducing the Duration of Untreated Psychosis

Chair: Lisa Dixon, M.D.

Presenters: Tara Niendam, Vinod Srihari, M.D.,

Michael L. Birnbaum, M.D.

Discussant: Susan Azrin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the barriers and facilitators individuals with first episode psychosis may experience on the pathway to care.; 2) Understand the importance of a population health perspective in organizing and implementing early detection and care for recent onset psychotic disorders.; 3) Understand how technology OR universal screening in appropriate settings can shorten DUP; and 4) Describe the potential role of the internet and search engines in shortening the pathway to care.

SUMMARY:

The period between the onset of first psychotic symptoms and treatment initiation, also known as the duration of untreated Psychosis (DUP), is a critical concern for the mental health system. Longer duration of untreated psychosis is associated with negative outcomes (for example, worse functioning), and efforts to understand it have focused on identifying delays along the pathway to care. Pathways are described in terms of help-seeking contacts, including formal and informal sources of help, and as heterogeneous and influenced by illness and contextual factors. DUP is also likely very much influenced by the nature of the care that could be provided and the extent to which it is engaging. Therefore, optimizing the impact of Coordinated Specialty Care and maximizing its impact requires addressing the pathways to care. This symposium will present an introduction to the concept of DUP and its relevance for early psychosis care. Dr. Dixon will present qualitative work from the RAISE-IES study summarizing the perceptions of service recipients and family members regarding facilitators and barriers to pursuing care in for early psychosis in New York City. Dr. Dixon will then describe the characteristics of the pathway to care for 779 service recipients of OnTrackNY, New York's coordinated specialty program. The pathway will be characterized from the onset of symptoms to the first mental health service contact to enrollment in OnTrackNY. She will examine how participant and contextual factors correlate with the DUP and the factors associated with time from onset of symptoms to first mental health service contact (help-seeking DUP). Dr. Niendam will describe the results of a cluster-randomized controlled trial that examined the impact of universal electronic screening for psychosis symptoms on DUP across a variety of community settings, and how a variety of barriers impacted individuals' access of CSC care. Dr. Srihari will describe will present findings from an NIH funded early detection campaign ('Mindmap') targeting a 10-town catchment in southern Connecticut, with a population of ~400,000. This effort to reduce delays to first antipsychotic prescription and enrollment in best practice Coordinated Specialty Care (CSC) was implemented over a 5 year period (2015-19) and assumed a population-based approach. Looking forward Dr. Birnbaum will describe upcoming efforts to explore

the role of search engine advertisements and interactive online engagement tools designed to connect users with specialty care staff and facilitate earlier treatment initiation. Dr. Azrin will summarize and synthesize the presentations.

Personalized Medicine in Psychiatry: Not Yet Realized, but a Bright Future

Chair: Charles Barnet Nemeroff, M.D., Ph.D.

Presenters: Charles R. Marmar, M.D., Joseph F. Goldberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how personalized medicine has revolutionized clinical practice in oncology and cardiology and has tremendous potential in psychiatry; 2) Understand the controversy surrounding the use of commercially available pharmacogenomic tests to predict antidepressant efficacy and side-effects; and 3) Understand the progress made in identifying biomarkers for post-traumatic stress disorder.

SUMMARY:

A remarkable body of research has emerged in the last two decades concerning personalized or Precision Medicine. Although definitions vary somewhat, personalized medicine is the approach to prevention, diagnosis and treatment that takes into account individual variability in genes, the environment and lifestyle for each patient. The goal is to be able to identify who in the population is at risk for particular disorders, aid in subtyping patients with a particular diagnosis to optimally identify the very best treatment for them. This is in contrast to the one-size-fits all approach that has been largely taken in the past, particularly by pharmaceutical companies in the development of novel agents. The goal is to provide individualized therapy with the highest likelihood of response with the least side effect burden. The two major research directions in personalized medicine is: 1. Identification of individuals in the general population who are at risk for one or another disorder. This has been explored, for example, in PTSD and mood disorders. 2. Identification of predictors of treatment response to one of the many FDA approved and evidence-based treatments for an individual patient. This has been

explored extensively in patients with major depression and has generated considerable controversy. The tools that have been most extensively utilized in such studies have been genomics and more recently brain imaging. In oncology, genomic testing have revealed subtypes of cancers, eg. breast, melanoma, lung cancer, that not only predict risk with great certainty (BRCA genes), but also predict the best chemotherapy to choose for an individual patient. Similar studies in cardiology have predicted optimal dosing of anticoagulants. The studies that seek genetic predictors of treatment response in psychiatry are based on the notion that variants in genes that code for targets of psychopharmacological agents, e.g serotonin transporter or SHT receptor genes will predict antidepressant response (pharmacodynamics) and genes that code for drug metabolism (e.g. cytochrome P450 isoenzyme system) will reliably predict side effects due to variations in drug levels (pharmacokinetics). Unfortunately the data justifying the use of commercial tests utilizing these approaches is far from convincing. As the field has matured, we have come to understand that a myriad of factors contribute to treatment response in mood disorders and PTSD including childhood maltreatment, recent life stressors, comorbid medical illness, family support, as well as genetics. Functional brain imaging studies have recently shown promise in predicting response to pharmacotherapy versus psychotherapy in patients with depression. As large scale studies are conducted with sufficient statistical power and a range of data are collected, machine learning techniques will be brought to bear to provide information to the practitioner on optimal treatment strategies for patients with major psychiatric disorders.

Psychiatrist Well-Being and Burnout Town Hall 3.0: Minority and Diverse Psychiatrists

Chair: Richard F. Summers, M.D.

Presenters: Bruce Jan Schwartz, M.D., Altha J. Stewart, M.D., Jose P. Vito, 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) Be aware of unique

issues minority and diverse psychiatrists face regarding wellbeing and burnout; 3) Identify three possible interventions which could improve your wellbeing and decrease burnout; and 4) Recognize the shared concerns psychiatrists struggle with regarding wellbeing and 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. Members of the committee will present data on burnout among our minority and ECP members, and the committee's recommendations to APA to support these members' regarding burnout and depression. The panelists, including APA leadership, will lead an open discussion on members' responses to burnout and experience with strategies for promoting wellbeing and combating burnout.

The Role of Interdisciplinary Collaboration in the Evolving Health Care System: Past, Present, and Future

Presenters: Laura Kelly, Ph.D., A.P.N., Candice Knight, Ph.D., Ed.D., A.P.N., PMHNP-BC, Barbara Sprung, D.N.P., PMHNP-BC, Certified Family Therapist
Discussant: Bruce Jan Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate new research and treatment strategies into clinical practice; 2) Identify and improve mental health disparities in the community; 3) Recognize how to bring new innovations into a variety of treatments to improve

patient care; and 4) Advance and update skills in community psychiatry treatment.

SUMMARY:

Increasingly, and especially in community settings, patient care is the responsibility of a multidisciplinary team of primary care physicians, social workers, nurses, and psychiatrists. Strong outcomes for patients require close collaboration between these disparate groups of professionals. When treatment prescribed by one physician can conflict with the objectives of another, potentially to deadly effect, our patients can no longer afford for their care team to remain siloed. The goal of this session is to begin the conversation, creating a lasting dialog between psychiatry and other branches of mental health. The panelists, deans of nursing in New York City, will discuss with APA President Dr. Bruce Schwartz the current barriers to collaboration, how such barriers can be addressed and overcome, and the future of interdisciplinary care. The welfare of our patients with serious mental illness is contingent upon a strong team of interdisciplinary professionals working together to improve patient outcomes. This session is a step toward the future of collaboration and coordinated mental health care.

Saturday, October 05, 2019

Disparities at the Intersection of Mental Health and Criminal Justice: A Round Table Discussion

Chair: Altha J. Stewart, M.D.

Presenters: Stephanie Le Melle, M.D., M.S., Sarah Yvonne Vinson, M.D., Judge Steven Leifman, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) After attending this session participants will understand the extent of the crisis, its disproportionate representation of persons of color, and the impact it is having on patients and the community.; 2) After attending this session participants will understand how they can model this behavior to address disparities in their own communities.; and 3) After attending this session participants will engage in conversations to address disparities in their own communities..

SUMMARY:

We need to have a discussion, this discussion will be uncomfortable, but it is necessary. This discussion is around the Disparities experienced within the Intersection of Mental Health and Criminal Justice. To have these discussions, we have to be willing to reach across, learn from experts in their fields, and accept our own faults, to truly move forward in addressing this public health crisis. During this 90 minute session we will model how to engage in these often difficult conversations with representation from psychiatry and the criminal justice field. During the first 45 minutes we will engage in modeling straight talk Round Table Discussion on Disparities. This portion will focus on how you can engage in these difficult conversations across the isle with the purpose of advocating to address the causes of the disparity. During the last 45 minutes the audience will be asked to provide questions to the experts, who will then respond and engage in conversations around that given question, we encourage participants to ask the difficult questions. This session will be utilized to create a Psych News Article on how psychiatrist can engage in conversations to address disparities in their own communities, which will feature the responses from select audience or prompted questions.

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

Presenter: Henry Samuel Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be familiar with challenges in interpreting and supporting research in cannabinoids; 2) Have reviewed medical history of marijuana; 3) Have reviewed neurochemistry of cannabinoids and cannabinoid system; 4) Have reviewed research on psychiatric/medical use of cannabinoids, including potential benefits, risks, hazards, and side effects; and 5) Have enhanced ability to educate and communicate with patients about cannabinoid use.

SUMMARY:

Marijuana, according to The National Institute on Drug Abuse, is “the most commonly used illicit

substance.” However, according to state, not federal, laws, medical marijuana is legal in 34 states and D.C. 11 states have also legalized recreational use of marijuana. As the legalizing of marijuana grows, more patients are turning to us, their doctors, for advice and information regarding 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 presentation will summarize the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. Dr. Levine 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. He will discuss the cannabinoid system, CB1 and CB2 receptors, their distribution and function, as well as the endogenous cannabinoids. He will cover cannabis’ routes of administration. He 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. He will also briefly review clinical research on its effects in non-psychiatric medicine. He will review hazards of cannabis use, including use in pregnancy, addiction, accidents, psychosis, cognitive deficits, withdrawal, heart and lung illnesses, reproductive effects, and other symptoms. He will discuss synthetic cannabinoids and CBD. Dr. Levine will describe the malpractice risks, legal restrictions, and limitations on medical practitioners who may be asked by their patients to issue a ‘cannabis card.’ He 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. He will propose an action agenda to improve education on and safety of cannabinoid use. He will not address screening for or treatment of addiction.

The Transformation of the Mental Health Association of NYC Into a National Tele-Behavioral Health Provider

Presenters: Kimberly Williams, Anitha Iyer, Ph.D., John Draper, Ph.D.

Discussant: Bruce Jan Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Integrate new research and treatment strategies into clinical practice; 2) Identify and improve mental health disparities in the community; 3) Recognize how to bring new innovations into a variety of treatments to improve patient care; and 4) Advance and update skills in community psychiatry treatment.

SUMMARY:

For over 50 years, Vibrant Emotional Health (formerly known as The Mental Health Association of New York City) has been offering high quality services and support to underserved populations in the NYC area. Over the years it has transformed from an advocacy and provider organization to using state-of-the-art technologies including social networks, telephone, text, chat and online services, to help people access care both locally and nationally. Vibrant provides 24/7 crisis services to millions throughout the country in partnership with local and federal governments and corporations including technology companies such as Lyra and Quartet. Services include the National Suicide Prevention Lifeline, the Veterans Crisis Line, and the NFL Life Line. Vibrant oversees NYC Well, the city's leading edge, multi-lingual contact center program that responds 24/7 to the mental health needs of tens of thousands of New Yorkers. This presentation will highlight Vibrant's evolution from a local organization into a national leader and will discuss its experience and challenges in leveraging technology to operate comprehensive crisis and referral services including the National Suicide Prevention, Veterans Crisis Lifelines, etc. to make

mental health referral, support and treatment accessible to people in crisis when, where, and how they want it.

Sunday, October 06, 2019

Climate Psychiatry: What Every Psychiatrist Should Know

Chair: Anne Shelton Richardson, M.D.

Presenters: Ekatherina Osman, D.O., Benson Ku, M.D., Janet Lisa Lewis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the mental health implications of climate change and the resulting need for services.; 2) Describe the trends in Acute Stress Disorder, PTSD, Major Depression and suicide in populations affected by climate disruption.; 3) Identify the impacts of extreme heat for psychiatric patients.; 4) Identify the developmental, psychiatric and cognitive impacts of air pollution.; and 5) Describe eco-anxiety and ecological grief..

SUMMARY:

The warming of our earth, derived primarily from the combustion of fossil fuels and large-scale animal agriculture, has led to multiple geophysical changes. These include alarming increases in extreme weather, intense heat, floods, droughts, fires, ocean acidification, air pollution and dramatic loss of biodiversity. The physical health impacts on humans might initially seem more obvious, but disabling mental health impacts are present today and will only increase over time. In this discussion, we will provide an overview of pertinent topics at the interface of climate change and mental health, exploring how our patients are affected by human activity. There is an increasing evidence base that correlates our changing climate to acute and chronic emotional distress and illness. Psychiatric patient populations, by virtue of their illnesses, socioeconomic status, and medications possess particular vulnerabilities to climate change. In this interactive presentation we will collectively explore relationships between heat and aggression, violence, mental health emergencies and suicide. We will review the impacts of air pollution on anxiety, neuropsychiatric developmental disorders and

dementia. The vast majority of Americans are now worried about climate change and, while that worry is generally not pathological, it combines with other social determinants to increase the stresses of living in a troubled world. These stresses can present in clinically significant ways. We will define recently emerging terms in the field such as ecoanxiety, “nature deficit disorder”, solastalgia, and ecological grief and their clinical implications. We will conclude with an interactive discussion of the recommended interventions at the individual clinical and public health levels.

LGBTQ Mental Health: From Closets to Communities

Presenter: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Create a welcoming environment for LGBTQ patients; 2) Identify unique mental health problems in LGBTQ populations; and 3) Provide culturally-informed and culturally-sensitive counseling to LGBTQ patients.

SUMMARY:

Society’s understanding of gender and sexual orientation has changed dramatically in the late 20th and early 21st centuries. When the gay civil rights movement symbolically started with the Stonewall Riots in New York City in 1969, LGBTQ people had been living in the closet since ancient times. Since then, a rainbow of gender and sexual identities has blossomed giving each person the potential to express and identify themselves as they see fit. Gender, previously thought to be strictly segregated into male and female, is now seen as a spectrum of many and sometimes fluid possibilities. The question is no longer, male or female, but what masculine and feminine traits each of us possess. We have added terms such as genderqueer, gender fluid, gender non-binary, intersex, and transgender to our understanding of how people live, love, work, and play. Sexual orientation has also evolved to encapsulate the diversity of sexual identity, sexual behavior, and sexual attraction. Most people used to identify as straight or gay, but many are now adopting the identities of bisexual, pansexual, asexual, queer, and questioning. Also, how someone

identifies does not necessarily imply how they behave sexually or what their sexual attractions may be. For example, men who live on the “down low,” identify as straight, sleep with both men and women, while their sexual attraction falls closer to the homosexual than the heterosexual end of the Kinsey scale. While the range of individual expression has grown over the past decade, equality and basic civil rights are far from being guaranteed for those who are gender and sexually diverse. Society continues to separate people into categories placing higher values and protections on those who fit the “traditional” notion of what it means to be human. I hope that this presentation will demystify some of the complexities of gender and sexuality, making our world a more accepting and inclusive place.