New Orleans

59th Institute on Psychiatric Services

APA's Leading Educational Conference on Public and Community Psychiatry

RECOVERY: Patients, Families, Communities

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

2007 CME Syllabus and Proceedings Summary

CONTINUING MEDICAL EDUCATION

SYLLABUS
AND
PROCEEDINGS SUMMARY

FOR THE

59th
INSTITUTE ON PSYCHIATRIC SERVICES

October 11-14, 2007
New Orleans, LA

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

AMERICAN PSYCHIATRIC ASSOCIATION

59TH INSTITUTE ON PSYCHIATRIC SERVICES

2007 SCIENTIFIC PROGRAM COMMITTEE

Stephen M. Goldfinger, M.D.
Chair, Scientific Program Committe
New York, NY

Jacqueline M. Feldman, M.D.
Vice Chair, Scientific Program Committee
Birmingham, AL

Anita S. Everett, M.D.
Committee Member
Baltimore, MD

Wesley E. Sowers, M.D.
Committee Member
Pittsburgh, PA

David A. Pollack, M.D.
Committee Member
West Linn, OR

CONSULTANTS

Edward F. Foulks, M.D., Ph.D.
Advocacy Consultant
New Orleans, LA

Janice Foulks, M.F.F.C.
Local Arrangements Consultant
New Orleans, LA

LIAISONS

Spencer Eth, M.D.
Liaison, Committee on Commercial Support
Englewood, NJ

Anthony J. Carino, M.D.
2006-2008 APA/Bristol-Myers Squibb Fellow
Bronx, NY

Howard H. Goldman, M.D., Ph.D.
Psychiatric Services Editorial Board
Potomac, MD

2007–2008 OFFICERS AND STAFF
AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901
Telephone: 703-907-(see extensions listed below)
E-Mail for Staff: First initial of first name, last name, and @psych.org

APA OFFICERS
Carolyn B. Robinowitz, M.D., *President*
Nada L. Stotland, M.D., M.P.H., *President-Elect*
Carol A. Bernstein, M.D., *Vice President*
Donna M. Norris, M.D., *Secretary/Treasurer*
Jeffrey Akaka, *M.D., Assembly Speaker*

MEDICAL DIRECTOR'S OFFICE
James H. Scully, Jr., M.D., *Medical Director and Chief Executive Officer*

OFFICE OF SCIENTIFIC PROGRAMS
Gary A. McMillan, M.A.L.S., M.S., *Acting Director,* x8648
Jill L. Gruber, CMP, *Associate Director*, *Institute on Psychiatric Services*, x7815
Nelea A. Johnson, *Program Assistant,* x7377
Donna N. McNelis, Ph.D.
Josh Wilk, Ph.D.
Joyce West, Ph.D., M.P.P.

DIVISION OF EDUCATION
Deborah J. Hales, M.D., *Director*, x8633
Kathleen Debenham, M.A., *Director, Department of Continuing Medical Education*, x8632
Dana Zook, *CME Program Manager*, *Department of Continuing Medical Education,* x8661
Linda Bueno, R.N., *Associate Director, Commerically-Supported Activities*, x7849

MEETINGS AND CONVENTIONS DEPARTMENT
Cathy L. Nash, CMP, *Director*, x7822
Hope Ball-Mann, *Registrar,* x7810
Jamal Hageb, *Senior Meeting Planner*, x7375
Kevin J. Klipsch, *Exhibits Manager*, (314) 994-9640

OFFICE OF COMMUNICATIONS AND PUBLIC AFFAIRS
Lydia Sermons-Ward, *Director*, x8534

TABLE OF CONTENTS

How to Obtain CME Credit .... i-ii

Daily Log for Attendance at CME Sessions iii

CEU Credit for Other Disciplines .... iv-v

Daily Log for Attendance at CEU Sessions v

Mission Statement vi

Industry-Supported Symposia 1-6

Innovative Programs 7-21

Lectures 22-29

Medical Updates 30

Posters 31-118

Symposia 119-152

Workshops 153-176

Index 177

Downtown New Orleans

This page intentionally left blank

HOW TO OBTAIN CME CREDIT FOR THE 2007 INSTITUTE ON PSYCHIATRIC SERVICES

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as category 1 for the 2007 Institute on Psychiatric Services (IPS) sessions meet the criteria for *AMA PRA Category 1 Credit™*.

The scientific program at the IPS offers a broad range of sessions designated for CME credit. The sessions that meet the criteria for *AMA PRA Category 1 Credit™* include Industry-Supported Symposia, Innovative Programs, Lectures, Medical Updates, Symposia, and Workshops. Other sessions may be reported as category 2 credit. These include Discussion Groups, Forums, APA Caucuses, and Posters.

NOTE: APA members must maintain their own record of CME hours for the meeting. To calculate credit, registrants should claim one credit for each hour of participation in *AMA PRA Category 1 Credit™* scientific sessions. To document credit, participants should record the session(s) attended on the Daily Log on page iii in this book. Documentation of all CME credit is based on the honor system.

RECORDING CME CREDIT THROUGH THE CME RECORDER

APA members can record the number of *AMA PRA Category 1 Credit™* they earn at the Institute on Psychiatric Services by completing the Computerized Evaluation Program and entering their CME hours. The hours entered on-site through the computerized evaluation are maintained for APA members in the personal CME Recorder section of APA's CME Web site.

The CME Recorder (for APA members) maintains a record of CME credits that are earned at APA annual meetings and entered through the Computerized Evaluation and online through APA CME web site programs. APA members may view and print these records from their personal computers. Members also have the capability to enter hours earned at other CME activities into their Recorder account.

APA members log in through the "Members Only" section of the APA Web site or through **http://www.psych.org/cme.** Select the *CME Recorder*, access your personal record, and view the hours you have earned through APA activities; view your APA CME certificate expiration date; learn about state CME requirements; and find direct links to state relicensing boards.

CME REQUIREMENTS FOR APA MEMBERS

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted that participation in continuing medical education (CME) activities be a condition of membership. The CME requirement aims at promoting the highest quality of psychiatric care through encouraging continuing professional growth of the individual psychiatrist.

Each member must participate in 150 hours of continuing medical education activities per three-year reporting period. Of the 150 hours required, a minimum of 60 hours must be in *AMA PRA Category 1 Credit™* activitives. *AMA PRA Category 1 Credit™* activities are sponsored or jointly sponsored by organizations accredited to provide CME and meet specific standards of needs assessment, planning, professional participation and leadership, and evaluation of learning.

(continued on next page)

CME REQUIREMENTS FOR APA MEMBERS
(Cont'd.)

In December 1983, the Board of Trustees ratified the current method of reporting CME activities. Although the basic requirement of 150 hours every three years (with at least 60 hours in category 1) remains the same, members no longer need to report these specific activities, but need only sign a compliance statement to the effect that the requirement has been met.

Individual members are responsible for maintaining their own CME records and submitting a statement of their compliance with the requirement after completing the necessary 150 hours of participation. **APA certificates are issued only upon receipt of a complete report of CME activities.** To receive an APA certificate, you can submit a completed APA report form or use one of the alternate methods detailed below. The APA Certificate is reciprocal with the Physicians' Recognition Award (PRA) of the American Medical Association.

HOW TO EARN A CERTIFICATE FOR MEMBER CME COMPLIANCE

APA CME certificate are issued to members upon receipt of a complete report of your CME activities. You can submit a completed APA report form (available upon request from the Department of Continuing Medical Education) and also through utilizing the CME recorder within the APA CME Web site - or use one of the following alternate reporting methods:

Submit:

- a copy of your current Physician's Recognition Award (PRA) from the American Medical Association, or
- a copy of your current re-registration of medical licensure from states which have CME requirements that are comparable to those of APA, or
- a copy of your current CME certificate from the state medical society of Kansas, New Jersey, Pennsylvania, or Vermont.
- You may also **report your CME activities directly to the APA**, using the official APA report form. This form may be obtained from the APA Office of Education, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901, or call (703) 907-8671; or electronically via the APA Web site at **http://www.psych.org/cme/apacme/home/cmereport.pdf**.

EXEMPTIONS

All APA Life Fellows and Life Members who were elevated to that membership category on or before May 1976 are exempt from the CME requirement, but are urged to participate in CME activities. Members who became Life Members or Fellows after that date are not exempt.

Any member who is inactive, retired, ill or disabled may request an exemption from the CME requirement by applying to his or her District Branch Membership Committee. After determination that partial or total exemption from CME activities is warranted, the District Branch Membership Committee will forward its recommendation to the APA Office of Education.

APA members residing outside of the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempt from the categorical requirements.

59th Institute on Psychiatric Services
APA's Leading Educational Conference on Public and Community Psychiatry

DAILY LOG FOR ATTENDANCE AT CME SESSIONS AT THE 59th INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 11-14, 2007 □ NEW ORLEANS, LA

NOTE: APA members are responsible for maintaining their own CME records. A copy of this certificate may be forwarded to other organizations requiring CME verification. Reporting of all CME is based on the honor system.

DAY		TITLE OF SESSION		NUMBER OF HOURS		CME CATEGORY (1 or 2)
				TOTAL		

CONTINUING EDUCATION CREDITS FOR OTHER DISCIPLINES

Conference Objectives

At the conclusion of the 2007 Institute on Psychiatric Services, participants will:

1) Recognize and improve mental health disparities in the community;
2) Demonstrate and apply new skills that will be useful in public psychiatry settings;
3) Utilize new knowledge and skills in clinical psychiatry that can be used to improve patient care;
4) Examine how the current health care system affects patient care;
5) Describe new ways to treat victims of trauma and violence in the commnity; and
6) Assess and evaluate all aspects of recovery.

Target Audiences

Administrators and Managers; Advocates and Policymakers; Consumer and Family Members; Educators, Faculty, and Training Directors; Medical Students and Residents; Nurses; Physicians (Nonpsychiatric); Planners, Researchers, and Evaluators; Psychiatrists; Psychologists; Rehabilitation Counselors; and Social Workers

Continuing Education Credits For Other Disciplines

Accreditation Statement:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Drexel University College of Medicine and the American Psychiatric Association. The Drexel University College of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Physicians should only claim credit commensurate with the extent of their participant in the activity.

APA (Psychology):

Drexel University College of Medicine, Behavioral Healthcare Education is approved by the American Psychological Association to sponsor continuing education for psychologists. Drexel University College Medicine, Behavioral Healthcare Education maintains responsibility for this program and its content. This program is offered for 40 credits.

ASWB (National Social Work):

This organization Drexel University College of Medicine, Behavioral Healthcare Education, provider #1065, has been approved as a provider for continuing education by the Association of Social Work Boards, 400 South Ridge Parkway, Suite B, Culpeper, VA 22701. www.aswb.org. ASWB. Social Workers should contact their regulatory board to determine course approval. Social workers will receive 40 continuing education clock hours in participating in this course.

PSNA (Nursing):

Drexel University College of Medicine, Behavioral Healthcare Education is an approved provider of continuing education by the PA State Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Participants will be awarded a maximum of 40 contact hours for attending this conference.

NBC (National Counselors):

Drexel University College of Medicine is recognized by the National Board for Certified Counselors to offer continuing education for National Certified Counselors. We adhere to NBCC continuing education guidelines. We can award a maximum of 40 hours of continuing education credits for this conference.

CEU's (IACET):

The Drexel University College of Medicine, Behavioral Healthcare Education has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The Drexel University College of Medicine, Behavioral Healthcare Education has awarded a maximum of 40 CEU's to participants who successfully complete this program.

Disclosure Statement

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

Please note that we are not offering CEU credit for APA Caucuses, Discussion Groups, Forums and Poster Sessions.

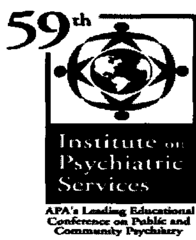
59th Institute on Psychiatric Services
APA's Leading Educational Conference on Public and Community Psychiatry

Drexel UNIVERSITY

DAILY LOG FOR ATTENDANCE AT CEU SESSIONS AT THE 59th INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 11-14, 2007 □ NEW ORLEANS, LA

NOTE: Use this form to keep your own attendance log at this conference.

DAY		TITLE OF SESSION		NUMBER OF HOURS
				TOTAL



MISSION STATEMENT

VISION, MISSION, VALUES, AND GOALS
of the
INSTITUTE ON PSYCHIATRIC SERVICES

VISION

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

MISSION

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

VALUES AND GOALS

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

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

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

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

Industry-Supported Symposium 1 | **Friday, October 12 12 Noon-1:30 p.m.**

INNOVATIVE APPROACHES TO BIPOLAR DISORDER: PART I

Supported by AstraZeneca Pharmaceuticals

Charles L. Bowden, M.D., *Chair and Professor of Psychiatry and Pharmacology, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Highlight differences in onset, episode duration, symptomatology and cultural issues between traditional criteria for bipolar disorders and recent research evidence; and 2.) Summarize practical new information on illness comorbidity, genetic factors, and maintenance interventions, including psychosocial treatments, to improve outcomes

SUMMARY:

Accurate diagnosis is essential to avoid treatment strategies that worsen illness course, particularly stability of mood. Bipolar disorders are increasingly seen as comprised of five to six dimensions of symptomatology and disturbed behavior. The complex presentations of bipolar disorders are further influenced by age, cultural and ethnic factors that, recognized, can insure that early effective interventions are implemented for diverse socioeconomic groups in all treatment settings. It is also increasingly clear that genes interact in important ways with each other and with environmental factors to influence risk, necessitating an understanding of cultural and other environmental differences between patients. Treatments for these components need to be tailored based on the spectrum of benefit of the drug or modality. Several large, randomized studies indicate added benefit of structured psychosocial interventions over that seen with usual care with medications in maintenance treatment of bipolar disorder. Several indices of recent depressive symptomatology are predictive of worse outcome with guideline based long term care. Studies have also found evidence of a poorer prospective course among subjects with lifetime or current anxiety disorders. Such data can meaningfully guide treatment decisions and monitoring of response during maintenance care. Each of these themes of assessment and long term interventions will be addressed by the speakers in this symposium.

No. 1A
DSM-IV AND NEW EVIDENCE ON ILLNESS COURSE, COMORBIDITY AND SYMPTOMS

Charles L. Bowden, M.D., *Chair and Professor of Psychiatry and Pharmacology, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900*

SUMMARY:

Recent national epidemiological studies indicate that persons with bipolar disorders have axis I and II comorbid conditions more often than seen in any other psychiatric disorder. Recognition of these patterns can allow an evaluating clinician to improve accuracy of, and make earlier diagnoses that recognize the bipolar component. Accurate diagnosis, utilizing evidence-based modifications of current criteria embodied in *DSM-IV*, indicate that the prevalence rate of bipolar I and II conditions is at least four percent. Accurate diagnosis is essential to avoid treatment strategies that worsen illness course, particularly stability of mood. Bipolar disorders are increasingly seen as comprised of five to six dimensions of symptomatology and disturbed behavior. Treatments for these components need to be tailored, based on the spectrum of benefit of the drug or modality. For example, lithium and divalproex show marked benefits on manic energy and impulsivity, but not on depression or psychosis. In contrast, lamotrigine has benefits on core features of depression, and atypical antipsychotics have marked benefits on components of both psychosis and mania, particularly elevated energy. These presentations are further influenced by age, cultural and ethnic factors that, recognized, can insure that early effective interventions are implemented for diverse socioeconomic groups in all treatment settings.

No. 1B
RECOVERY OF THE ELDERLY BIPOLAR: THE PSYCHIATRIC-MEDICAL NEXUS OF CARE

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

SUMMARY:

Family and twin studies suggest that Bipolar Disorder is highly heritable, and recent association studies have implicated polymorphisms in a number of genes in increasing risk for Bipolar Disorder. As such genes are identified, they may begin to inform clinical approaches to Bipolar Disorder in several respects. First, they highlight the extent to which risk genes may cross traditional

nosological boundaries; for example, they may contribute to risk for psychotic symptoms regardless of primary diagnosis. Second, they may clarify the reasons that comorbidity is so common in Bipolar Disorder. Third, they may clarify the mechanisms by which known bipolar pharmacotherapies act, and help to identify targets for new drugs. Finally, they may help clinicians to better stratify risk in Bipolar Disorder, and ideally create more individualized treatment regimens. It is also increasingly clear that genes interact in important ways with each other and with environmental factors to influence risk, necessitating an understanding of cultural and other environmental differences between patients.

REFERENCES:

1. Kessler RC, Chiu WT, Demier O, Merikangas KR, Walters EE, 2005, Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, v 62, p 590–592
2. Post RM, et al.: An overview of recentfindings of the Stanley Foundation Bipolar Network (SFBN) (Part II): Focuson anticonvulsants. Aspects of Affect 2005; 1:8–17.

Industry-Supported Symposium 2 — **Friday, October 12, 6:30 p.m.-9:30 p.m.**

INTEGRATING PHYSICAL AND MENTAL HEALTH DURING ANTIPSYCHOTIC TREATMENT

Supported by Bristol-Myers Squibb Company

Christoph U. Correll, M.D., *Assistant Professor of Psychiatry and Behavioral Sciences, The Zucker Hillside Hospital, 75-59 263rd St., Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to: 1.) Relate the therapeutic and adverse effects of antipsychotics to patient satisfaction, wellness and adherence; 2.) Describe the effects of antipsychotics on a variety of adverse effect clusters, such as prolactin and sexual functioning, weight and metabolic health, sedation and cognition, as well as extrapyramidal symptoms; and 3.) Develop and apply treatment algorithms that integrate physical and mental functioning.

SUMMARY:

Second-generation antipsychotics are increasingly recognized as having broad efficacy for a variety of disorders and syndromes, including psychosis, mania, aggression and agitation, depression, anxiety and insomnia. However, with this increased usage, more attention needs to focus on the potential adverse effects that are associated with specific treatments. Moreover, a better understanding is needed of the interaction and potential relationship between specific efficacy spectra and adverse effects. This symposium will address the general relationship between adverse effects and patients satisfaction and treatment adherence, as well as the beneficial effect of shared decision making. In addition, key adverse event clusters and their relationship to efficacy and outcomes will be addressed that have been identified by research as being of relevance. This includes the area of sedation and its relationship to the treatment of psychosis, agitation and aggression as well as cognitive and functional outcomes. This also includes the effect of antipsychotics on prolactin and prolactin-related adverse effects, as well as the discussion of the relevance of prolactin levels that are not associated with overt clinical effects. Furthermore, the relative effect of antipsychotics on extrapyramidal adverse events and metabolic effects that have major importance for overall health will be discussed. Finally, we will summarize the evidence for the most appropriate choice of strategies to assess and manage each of these adverse effects to improve patient adherence, satisfaction and outcome.

No. 2A
THE ROLE OF ANTIPSYCHOTIC ADVERSE EFFECTS FOR PATIENT WELLNESS

Christoph U. Correll, M.D., *Assistant Professor of Psychiatry and Behavioral Sciences, The Zucker Hillside Hospital, 75-59 263rd St., Glen Oaks, NY 11004*

SUMMARY:

Second-generation antipsychotics are increasingly recognized as having broad efficacy for a variety of disorders and syndromes including psychosis, mania, aggression and agitation, depression, anxiety, and insomnia. However, with this increased usage, more attention needs to focus on the potential adverse effects that are associated with specific treatments. Moreover, a better understanding is needed of the interaction and potential relationship between specific efficacy spectra and adverse effects. This symposium will address the general relationship between adverse effects and patients satisfaction and treatment adherence, as well as the beneficial effect of shared decision making. In addition, key adverse event clusters and their relationship to efficacy and outcomes will be addressed that have been identified by research as being of relevance. This includes the area of sedation and its relationship to the treatment of psychosis, agitation and aggression, as well as cognitive and functional outcomes. This also includes the effect of antipsychotics on prolactin and prolactin-related adverse effects, as well as the discussion of the relevance of

prolactin levels that are not associated with overt clinical effects. Furthermore, the relative effect of antipsychotics on extrapyramidal adverse events and metabolic effects that have major importance for overall health will be discussed. Finally, we will summarize the evidence for the most appropriate choice of strategies to assess and manage each of these adverse effects to improve patient adherence, satisfaction and outcome.

No. 2B
THE ROLE OF ANTIPSYCHOTIC ADVERSE EVENTS FOR WELLNESS AND ADHERENCE: BALANCING PHYSICIAN AND PATIENT PERSPECTIVES

Peter F. Buckley, M.D., *Professor and Chair, Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*

SUMMARY:

Clinicians are presented with invariably confusing- and often even conflicting- information on the relationship between adverse effects and antipsychotic medications. Moreover, there is interest in promoting better integration of physical and mental health wellness, in part reflected by our efforts to undertake close monitoring for metabolic disturbances during antipsychotic therapy. For clinicians, it can be difficult to put all these into perspective and key questions that arise are, ''How best should I explain these risks to my patient?''.... ''What are the right choices here?''.... and ''How best can I encourage my patient to stay the course in care in the face of potentially serious adverse effects?''. Indeed, the impact of adverse effects on medication adherence is substantial, inordinately complex, invariably interrelated, and goes beyond the anticipated difficulties with taking medications consistently in other chronic medical illnesses. Current approaches to detecting medication nonadherence include patient and caregiver interviews, pill counts, electronic monitoring, and estimation of plasma levels of antipsychotic medications. Emergent approaches to enhancing adherence include sophisticated medication formulations and delivery systems, telecommunication innovations to provide prompts to remind patients about medication schedules, and targeted psychological therapies. In the end of all, the importance of informed consent and shared decision making (''treatment alliance... not compliance'') are critical in managing the complex medication profile and in balancing physician and patient perspectives.

No. 2C
ANTIPSYCHOTIC EFFECTS ON PROLACTIN-REGULATED REPRODUCTIVE, IMMUNE AND BONE INTEGRITY

Harold E. Carlson, M.D., *Professor and Chairman, Department of Psychiatry, Stony Brook University, HSC T15-060, Stony Brook, NY 11794*

SUMMARY:

Serum prolactin (Prl) increases when most antipsychotics are started, and then often declines over time. Although many patients are asymptomatic, menstrual and sexual dysfunction are common; galactorrhea and gynecomastia are rare. Pubertal development appears to be normal. Osteoporosis may occur with persistent hypogonadism. The degree of hyperprolactinemia induced by antipsychotics is, roughly: risperidone>olanzapine= zip-rasidone>quetiapine>aripiprazole. Pituitary tumors have been reported in patients receiving antipsychotics, but are also common incidental findings (3–27%) in the general population, and causality has not been established. Aripiprazole, a partial dopamine agonist, lowers serum prolactin; hypoprolactinemia can inhibit post-partum lactation, and could theoretically alter gonadal, adrenal or immune system function. Conclusions: In patients receiving antipsychotics, serum Prl should be measured if relevant symptoms are present. Changes in dose or drug may correct symptomatic hyperprolactinemia. Addition of aripiprazole to the antipsychotic regimen may lower Prl levels. Additional medication may be prescribed to treat the consequences of elevated Prl.

No. 2D
SEDATION: REQUIRED INGREDIENT FOR RESPONSE OR ROADBLOCK TO REMISSION?

Del Miller, M.D., Pharm.D., *Psychiatry Research, University of Iowa College of Medicine, #2-105 Medical Education Building, 500 Newton Road, Iowa City, IA 52242*

SUMMARY:

Individuals with schizophrenia and other serious mental illnesses frequently suffer from sleep disturbances such as insomnia or excessive sleeping. Sedation is a common effect of the first-generation antipsychotic medications, particularly at higher doses. The second-generation antipsychotic agents generally cause less sedation and vary among themselves in the degree of sedation that they produce. The amount of sedation associated with each antipsychotic seems to be at least par-

tially related to their affinity for histamine H1 receptors and to dosage. While sedation can be desirable in the acute treatment of psychosis and agitation, it may interfere with a person's ability to benefit from other therapeutic interventions, cognitive performance, and to function normally over the long term. Historically, the sedation associated with first-generation antipsychotic agents was considered a sign of efficacy. Recent studies, however, have shown that newer antipsychotic agents effectively control both psychosis and acute agitation with minimal sedation. Use of these agents may achieve acute control while allowing the patient to participate in therapeutic and normal daily activities.

No. 2E
EXTRAPYRAMIDAL SYMPTOMS AND TARDIVE DYSKINESIA IN THE ERA OF ATYPICAL ANTIPSYCHOTICS

John M. Kane, M.D., *Chair, Department of Psychiatry, The Zucker Hillside Hospital; and Professor of Psychiatry, Neurology, and Neuroscience, Albert Einstein College of Medicine, 75-59 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

The use of antipsychotic medications has long been limited by their adverse effects on neuromotor functioning. Extrapyramidal adverse effects are important for patient satisfaction, treatment adherence, social integration and relapse prevention. From a patient perspective and negative effects on medication adherence. Compared to conventional neuroleptics, second-generation antipsychotics are generally associated with lower rates of acute extrapyramidal effects, such as parkinsonism, dystonia, akathisia (Kane 2003). However, incidence rates vary across first- and second-generation antipsychotics and are dose related. While the mechanisms of parkinsonian side effects and dystonia are generally well understood, mechanisms for akathisia are much less clear. Furthermore, recent studies (Lee et. al., 2005; Lieberman et.al., 2005) have begun to challenge the finding that second-generation antipsychotics are associated with a reduced incidence of extrapyramidal side effects and tardive dyskinesia (Correll et.al., 2004). In this presentation, incidence rates, risk factors and mechanisms for acute and chronic neuromotor effects of antipsychotics will be reviewed. In addition, the effect of study design and methodology for the evaluation of extrapyramidal effects will be discussed. Finally, management options will be outlined, such as dose reduction, switching to a lower risk agent, starting with a lower risk agent, or augmenting with a medication that reduces the adverse neuromotor effect.

No. 2F
ANTIPSYCHOTICS AND THE INSULIN RESISTANCE SYNDROME: WHERE DO WE STAND AND WHERE DO WE GO?

Christoph U. Correll, M.D., *Assistant Professor of Psychiatry and Behavioral Sciences, The Zucker Hillside Hospital, 75-59 263rd St., Glen Oaks, NY 11004*

SUMMARY:

Patients with mental disorders are more likely to be overweight or obese than the general population. They are also at higher risk for associated glucose and lipid abnormalities and accelerated coronary heart disease. In addition to illness-related factors, psychiatric treatments required to reduce psychiatric morbidity and mortality can aggravate theses negative health outcomes. It is of relevance to the clinician, patient and their family members to understand the impact of sedentary lifestyle, poor dietary habits and weight gain on metabolic health and survival. In addition, the weight-related and some weight-independent effects of antipsychotics on metabolic health status need to be taken into consideration during treatment planning and management. Key questions relate to the areas of timing, feasibility and efficacy of lifestyle interventions or pharmacological treatments aimed at reducing coronary heart disease risk. Furthermore, health care professionals, administrators and policy makers need to reach agreement on whose responsibility the health monitoring and treatment is and where the resources are going to come from. As in other fields of medicine, using lower-risk agents first is a viable primary preventive strategy. In order to achieve improved integrated outcomes, patients and family members should be involved in deciding about the most appropriate choice of medications and monitoring intervals.

REFERENCES:

1. Miller DD. Atypical Antipsychotics: Sleep, sedation, and efficacy. Prim Care Companion J Clin Psychiatry 2004;6 Suppl 2:3–7.
2. Straker D, Correll CU, Kramer-Ginsberg E, et al. Cost-effective screening for metabolic syndrome in patients treated with second-generation antipsychotic medications. Am J Psychiatry 2005;2: 1217–21.
3. Buckley PF, Wirshing DA, Bushan P, et al. Insight and medication adherence in schizophrenia. CNS Drugs 2007 (in press)
4. Correll CU, Carlson HE. Endocrine and metabolic adverse effects of psychotropic medications in children and adolescents. J Am Acad Child Adolesc Psychiatry 2006; 45: 771–791.
5. Correll CU, Frederickson AM, Kane JM, Manu P. Metabolic syndrome and the risk of coronary heart

disease in 367 patients treated with second-generation antipsychotic drugs. J Clin Psychiatry. 2006 Apr;67(4):575–83.
6. Correll CU, Leucht S, Kane JM. Lower risk for tardive dyskinesia associated with second-generation antipsychotics: a systematic review of 1-year studies. Am J Psychiatry. 2004 Mar;161(3):414–25.
7. Jones PB, Barnes TR, Davies L, Dunn G, Lloyd H, Hayhurst KP, Murray RM, Markwick A, Lewis SW. Randomized controlled trial of the effect on Quality of Life of second- vs first-generation antipsychotic drugs in schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1). Arch Gen Psychiatry. 2006 Oct;63 (10):1079–87.
8. Kane JM. Extrapyramidal side effects are unacceptable. Eur Neuropsychopharmacol. 2001 Oct;11 Suppl 4:S397–403.
9. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe RS et al.; Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med. 2005;353(12): 1209–23.
10. Miller DD. Atypical antipsychotics: sleep, sedation, and efficacy. Prim Care Companion J Clin Psychiatry. 2004;6(Suppl 2):3–7.
11. Perlis RH, Baker RW, Zarate CA Jr, Brown EB, Schuh LM, Jamal HH, Tohen M. Olanzapine versus risperidone in the treatment of manic or mixed States in bipolar I disorder: a randomized, double-blind trial. J Clin Psychiatry. 2006 Nov;67 (11):1747–53.

Industry-Supported Symposium 3 — **Saturday, October 12, 12 Noon-1:30 p.m.**

INNOVATIVE APPROACHES TO BIPOLAR DISORDER: PART II

Supported by AstraZeneca Pharmaceuticals

No. 3A
PSYCHOSOCIAL INTERVENTIONS THAT IMPROVE OUTCOMES IN BIPOLAR DISORDER

Jodi M. Gonzalez, Ph.D., *Department of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, MC 7792, San Antonio, TX 78229*

SUMMARY:

Several large, randomized studies indicate added benefit of structured psychosocial interventions over that seen with usual care with medications in maintenance treatment of Bipolar Disorder Cognitive, interpersonal, psychoeducational, and family therapy approaches have demonstrated benefit, in individual and group formats. Putative active components of each approach will be described. The benefits of psychotherapy tend to dissipate following its discontinuation. Psychosocial treatments are being developed for children, adolescents and persons with comorbid substance abuse. Limitations of the studies conducted to date include selective samples that, have generally involved higher functioning patients, with better social and community resources and limited ethnic diversity. In particular, illness severity, ethnic factors and lower socioeconomic status may mitigate against benefits from current psychosocial approaches. Clinical examples of common psychotherapeutic themes across the spectrum of bipolar disorders, and the variability of issues from social to symptomatic and from role function to illness understanding will be presented.

No. 3B
WHAT WE KNOW ABOUT MAINTENANCE TREATMENT FOR BIPOLAR DISORDER

Lori L. Altshuler, M.D., *Department of Psychiatry and Behavioral Sciences, University of California at Los Angeles, 300 UCLA Medical Plaza, Room 1544, Los Angeles, CA 90095-7057*

SUMMARY:

Recent large, principally blinded, randomized placebo controlled maintenance studies in bipolar patients provide clinically relevant evidence that can aid psychiatrists in maintenance treatment planning. Studies indicate that for several drugs, e.g., lamotrigine, divalproex, atypical antipsychotics, and drugs effective during acute phase treatment are likely to provide continued effectiveness during maintenance care.

In some studies, poor tolerability of lithium in relation to other medications have been reported. Maintenance tolerability varies greatly among atypical antipsychotics, with components of the metabolic syndrome, e.g., insulin resistance and weight gain more common and severe with olanzapine and clozapine than, particularly, aripiprazole and ziprasidone. The safety and efficacy of traditional antidepressants is a complex issue. A small proportion of bipolar patients appear to benefit from longer-term continuation of traditional antidepressants. However, other of patients so treated appear to have some worsening of manic symptomatology. More adequately powered studies need to be performed to assess long term benefit versus destabilization with continued antidepressant exposure. Lamotrigine and quetiapine, both of which have antidepressant properties in some aspects

of Bipolar Disorder, do not appear to cause mood destabilization. Stanley Foundation Network data and NIMH STEP BD data have yielded evidence for several predictors of outcomes during maintenance. For example, several indices of recent depressive symptomatology are predictive of worse outcome with guideline- based care. Studies have also found evidence of a poorer prospective course among subjects with lifetime or current anxiety disorders. Such data can meaningfully guide treatment decisions and monitoring of response during maintenance care.

REFERENCES:

1. Frank E, Kupfer DJ, Thase ME, Mallinger AG, Swartz HA, Fagiolini AM et al.: Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Arch Gen Psychiatry 2005; 62:996–1004
2. Green EK et al: Free Full Text Operation of the schizophrenia susceptibility gene, neuregulin 1, across traditional diagnostic boundaries to increase risk for bipolar disorder. Arch Gen Psych 2005;62: 642–8.
3. Post RM, et al.: An overview of recentfindings of the Stanley Foundation Bipolar Network (SFBN) (Part II): Focuson anticonvulsants. Aspects of Affect 2005; 1:8–17.

INNOVATIVE PROGRAMS: SESSION 1

TRAINING AND TRANSFORMATION

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

MOVING TOWARD RECOVERY: NETWORKING FOR CHANGE

Allison N. Ponce, Ph.D., *Assistant Professor of Psychiatry, Yale University School of Medicine, 34 Park Street, Room 144, New Haven, CT 06519*; Thomas H. Styron, Ph.D., *Associate Professor of Psychiatry, Yale University School of Medicine, 34 Park Street, Room 144, New Haven, CT 06519*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of how community agencies are implementing recovery initiatives.

SUMMARY:

As the recovery movement revolutionizes mental health care, providers are implementing change in the delivery of services. Resources for individuals with serious mental illness are being transforming to reflect the understanding that people can and do recover. The Community Services Network (CSN) of Greater New Haven is a consortium of 17 community-based agencies that provide clinical, residential, vocational, and social rehabilitative services to over 5,000 individuals with serious mental illness per year. The State of Connecticut funds these providers and pulls them together as a network to coordinate services and strengthen the resources of the community. Becoming more recovery-oriented has been the CSN's priority, and the support and collaboration among the providers has allowed for significant strides to be made. This program will focus on the power of a network to implement change. Specifically, we will discuss how training and education are used to support recovery transformation, ways in which changing a network's culture on multiple levels influences acceptance of new ideas, and how effective leadership impacts the implementation of recovery principles. Some specific examples include the CSN's strategic planning process, ongoing quality assurance and improvement efforts, and the network's Training Institute.

REFERENCES:

1. Davidson L, Flanagan E, Roe D, Styron T: Leading a horse to water: an action perspective on mental health policy. Journal of Clinical Psychology 2006; 62(9):1141–1155.
2. President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Department of Mental Health and Human Services, pub no SMA-03-3832, Rockville, MD, 2003.

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

THE TRANSFORMATION OF MINNESOTA STATE OPERATED SERVICES ADULT MENTAL HEALTH

Alan Q. Radke, M.D., M.P.H., *Chief Medical Officer, State Operated Services, Minnesota Department of Human Services, 444 Lafayette Road, North St. Paul, MN 55164-0979*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Define the history of Minnesota (MN) State Operated Services transformation; 2.) Identify the context in which MN State Operated Services working with regional planning groups developed community behavioral health hospitals; and 3.) Explain the role and operation of Central Preadmission.

SUMMARY:

In 1987, as a result of a declining institutional bed census, the State of Minnesota (MN) created a vision of a community infrastructure that could result in the transformation of the public mental health system from an institutionally-based model of care to a community-based model of care. Over the years, multiple legislative supported initiatives have resulted in an array of community services including crisis services, intensive residential services, assertive community treatment teams, adult mental health rehabilitation services and other waiver services. In 2002, the Greater MN regional planning groups, with the support of the MN Department of Human Services budget, began a process to replace state hospital beds with community-based inpatient beds. As a result, State Operated Services has developed a network of bed community behavioral health hospitals and closed the state hospitals in Greater MN. To support this new network of hospital beds, State Operated Services also developed a central preadmission process which allows a referral source to contact a single access point and improves system-wide bed management. Conversations with the metro counties focused on similar initiatives have begun.

REFERENCES:

1. Aarons GA: Tranformational and Transactional Leadership: Association With Attitudes Toward Evi-

dence-Based Practice. Psychiatric Services 57: 12–19, 2006.
2. Arfken CL, Zeman LL & Koch, A: Perceived Impact by Administrators of Psychiatric Emergency Services After Changes in a State's Mental Health System. Community Mental Health Journal 42: 281–290.

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

PSYCHIATRIC ADMINISTRATION: DO I REALLY NEED A BUSINESS DEGREE?

Lydia E. Weisser, D.O., M.B.A., *Clinical Director, Mississippi State Hospital, P.O. Box 157-A, Whitfield, MS 39193*; Andrea C. Bradford, M.D., *4280 Ball Ground Road, Ball Ground, GA 30107-4371*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize at least two types of graduate business degrees and their relevance to psychiatric administrative careers.

SUMMARY:

As more psychiatrists are being promoted into and attracted to careers in psychiatric administration, it is clear that additional training is needed in essential business skills. These skills include human resource management, business ethics, management theory, financial decision-making, and health care policy to name a few. Although numerous business programs are available, understanding and selecting appropriate training is often difficult and confusing. This innovative program will compare similarities and differences among the MBA, MMM, and MSHA degrees, as well as discuss program content, approximate cost, and length of time to completion.

REFERENCES:

1. Stahl MJ, Dean PJ: The Physician's Essential MBA: What Every Physician Leader Needs to Know. Knoxville, TN, Aspen Publishers, 1999.
2. Reid WH, Silver SB (eds.): Handbook of Mental Health Administration and Management. New York, NY: Brunner-Rutledge, 2003.

INNOVATIVE PROGRAMS: SESSION 2

REGIONAL RESPONSES TO KATRINA: PLANNING FOR THE FUTURE

OMNA on Tour in the Gulf Coast Track

Innovative Program 4 **Thursday, October 11 1:30 p.m.-3:00 p.m.**

STEPPING UP TO THE PLATE: THE RESPONSE OF HOUSTON LEADERS TO THE GULF COAST HURRICANES OF 2005

OMNA on Tour in the Gulf Coast Track

Rahn Bailey, M.D., *Bailey Psychiatric Association, 614 W. Main, Suite D101, League City, TX 77573*; Allison M. Nitsche, M.D., *2006–2008 APA/Bristol-Myers Squibb Fellow; and Resident, Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, BCM 350, Houston, TX 77030*; Kathy Scott-Gurnell, M.D., *2800 S. Macgregor Way, Houston, TX 77021*; Napoleon B. Higgins, Jr., M.D., *Chief Executive Officer, Child, Adolescent, and Adult Psychiatry Department, Bay Pointe Behavioral Health Service, Inc., 1560 W. Bay Area Boulevard, #110, Friendswood, TX 77089*; Xyna Bell, Ph.D., *Psychologist, 2225 Herman Drive, Houston, TX 77004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Understand the response of Houston leaders to the Hurricane Disasters of 2005; 2.) Analyze the response for potential areas of improvement; and 3.) Discuss necessary changes to the regulatory environment that limited access to available resources.

SUMMARY:

In the aftermath of disaster, a variety of institutions, professional, and community organizations came together to address the unmet mental health needs of Hurricane Katrina evacuees. The victims of Hurricane Katrina arrived at the Houston Astrodome/Reliant Center; distraught, disoriented, and terrified. Although for many, the disaster gave rise to psychiatric issues, most evacuees already had pre-existing psychiatric disorders. Nonetheless, several leaders, experts, and organizations collaborated to provide outstanding psychiatric care against tremendous adversity. This workshop will focus on analyzing this model of collaboration between professional organizations, governmental agencies, and community organizations. Disaster specific issues will be discussed to highlight areas that are of critical concern in disaster psychiatry. Finally, the presenters will review important areas where solutions are needed. Specifically, we must address the significant regulatory burdens that essentially limited access to otherwise available resources.

REFERENCES:

1. T.F.Gavagan, K.Smart, H. Palacio, C. Dyer, S. Greenberg, P. Sirbaugh, A. Fishkind, D. Hamilton, U. Shah, G. Masi. R. T. Ivey, J. Jones, F. Y. Chiou-Tan, D. Bloodworth, D. Hyman, C. Whigham, V. Pavlik, R. D. Feigin, K. Mattox, Hurricane Katrina:

Medical Response at the Houston Astrodome/Reliant Complex. Southern Medical Journal. Volume 99, No. 9, September 2006, pg. 933–939.
2. Medscape: Psychiatry and Mental Health http://www.medscape.com/viewarticle/513389 by Michele Late; Kim Krisberg Accessed on December 19, 2006.

Innovative Program 5 Thursday, October 11 1:30 p.m.-3:00 p.m.

A VIEW FROM THE FRONT LINES: LEARNING DISASTER PSYCHIATRY ON THE RUN

OMNA on Tour in the Gulf Coast Track

Elizabeth C. Henderson, M.D., *Henderson Clinic, 359 Towne Center Boulevard, Suite 601, Ridgeland, MS 39157-4862*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) List four clinical areas in addition to trauma disorders that require attention following a disaster; 2.) Describe a method for establishing communication and assessing ongoing needs in a disaster. 3.) Identify two strategies of self care for clinicians in a disaster; and 4.) Utilize an emergency preparedness plan for patients.

SUMMARY:

Although there is considerable literature on disaster psychiatry, a disaster is just that – destruction of the expected and full of unexpected challenges. Ninety miles of Mississippi coastline was obliterated, but the destruction blew inward further than anyone imagined beforehand. In this presentation, personal experiences are discussed with an emphasis on the need for creativity, flexibility, and a solid grounding in the principles of disaster psychiatry and the varied effects of trauma on a diverse population. What became apparent is that the available information on trauma reactions failed to capture the breadth of need that arose during Katrina. From chronic mental illness to mental retardation to opiate addiction to delirium and dementia, the clinical demands on a clinician in the disaster area went far beyond dealing with traumatic stress. Compounding these professional challenges was the personal experience of trauma, loss, and exhaustion. This innovative program will conclude with a discussion of useful basic skills and pointers that the participant can use, including maintaining communication and connections, assessing on-going needs, accessing services, and emergency preparedness for patients.

REFERENCES:

1. Silove, Derrick and Bryant, Richard: Rapid Assessments of Mental Health Needs After Disasters, JAMA, Vol. 296, No. 5, pp 576–578.
2. Communicating in a Crisis: Risk Communication Guidelines for Public Officials, U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Rockville, MD, 2002.

Innovative Program 6 Thursday, October 11 1:30 p.m.-3:00 p.m.

ONCE BIT - TWICE SHY: APPLYING LESSONS LEARNED FROM KATRINA ABOUT DISASTER MENTAL HEALTH IN MISSISSIPPI

OMNA on Tour in the Gulf Coast Track

Catherine S. May, M.D., *Private Practice, 2000 P Street, N.W., Suite 601, Washington, DC 20036-6971*; Elizabeth C. Henderson, M.D., *Henderson Clinic, 359 Towne Center Boulevard, Suite 601, Ridgeland, MS 39157-4862*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) List three examples that illustrate the benefits of integrating psychiatric and primary care. 2.) Describe a structured model for working with primary care physicians and nurse practitioners; 3.) List five functions of the Behavioral Health Strike Team; and 4.) Describe interagency and intra-discipline contacts necessary to establish and maintain teams.

SUMMARY:

When the world changed in Mississippi on August 29, 2005, Mississippi psychiatrists realized we were not prepared. Volunteer psychiatrists encountered many logistical and other problems in delivering timely and appropriate psychiatric care in often primitive disaster medical relief centers. Since then, a collaborative group of mental health professionals in Mississippi, informed by the experiences of those in the trenches, have been working towards the development of a Behavioral Health Strike Team that will be incorporated into the state's improved disaster medical response system. This workshop covers anecdotal and statistical information derived from the experiences of two presenters at a disaster relief center in Long Beach, MS and goes on to describe the development and functioning of a modular, team based, behavioral health response system that is incorporated into the National Incident Management System model. Issues covered include systems problems and solutions, training needs, collaborative issues including within behavioral health disciplines as well as with primary care,

service allocation among diverse tasks and demands, and provision of services to children/adolescents, special needs populations, and minority/disadvantaged groups. As this project is a work in progress, discussion and input from participants will be welcomed.

REFERENCES:

1. Ursano, Robert J and Friedman, Matthew J: Mental Health and Behavioral Interventions for Victims of Disasters and Mass Violence: Systems, Caring, Planning, and Needs: In Interventions Following Mass Violence and Disasters; Edited by Ritchie, Elspeth Cameron, Watson, Patricia J., Friedman, Matthew J., New York, Guilford Press, 2006, pp 405–414.
2. FEMA Independent Study Program: IS-700 National Incident Management System (NIMS), Facilitators Guide; Federal Emergency Management Administration, August 2004.

INNOVATIVE PROGRAMS: SESSION 3

ESTABLISHING UNIQUE SERVICES

Innovative Program 7 Thursday, October 11 3:30 p.m.-5:00 p.m.

UTILIZATION OF SERVICES AND UNMET NEEDS IN SUICIDE COMPLETERS: AN INNOVATIVE APPROACH

Johanne Renaud, M.D., *Depressive Disorders Program, Douglas Hospital, 6875 LaSalle Boulevard, Montreal, PQ, Canada H4H 1R3*; Monique Sequin, Ph.D.; Alain D. Lesage, M.D.; Gustavo Turecki, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an innovative approach to study and recognize suicide risk factors in youths and young adults.

SUMMARY:

Many studies have looked at suicide risk factors, but there exists little research or documentation, with the exception of audit and coroner's reports or media scandals following a suit, on the adequacy of services for youths at risk of suicide. Consequently, our aim was to study trajectories of utilization of services used in the last 12 months of the lives of suicide victims and youths at risk of suicide in the province of Quebec. The goal of this presentation is to share an innovative method designed to determine the needs for services and care at the individual, local, regional, and provincial levels, as well as plan the organization of the services to be established for preventing suicide. The data collection rests on the principles of needs assessment procedures for severely mentally ill patients, for community cases of common mental disorders and from our previous experience in another Canadian province (NB). Standardized recordings from informants and all available records of utilization of services are examined; then a panel of experts review all the information summarized in a narrative, and establishes the needs for care and services at different levels of services.

REFERENCES:

1. Luoma JB, Martin CE, Pearson JL (2002), Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 159: 909–9.
2. Thornicroft G and Tansella M. (1994). Designing instruments for mental health service research. Social Psychiatry and Psychiatric Epidemiology 29, 197.

Innovative Program 8 Thursday, October 11 3:30 p.m.-5:00 p.m.

EQUINE ASSISTED PSYCHOTHERAPY AS A TREATMENT FOR PTSD

Joseph Iancia, D.O., *Clinical Assistant Professor of Psychiatry, University of Rochester Medical Center, 75 Walker Road, Hilton, NY 14468*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential benefit of Equine Assisted Psychotherapy in the treatment of PTSD in veterans and their families.

SUMMARY:

This presentation will cover the basic elements of Equine Assisted Psychotherapy with specific emphasis on its role in treating PTSD in veterans and their families. It will cover the potential metaphors that evolve in this work around issues of rejoining a community, challenges involved in forming intimate relationships, problem solving and overcoming obstacles in returning from war and re-entering civilian life, and identification of important aspects of civilian life and threats to regaining these. It is intended for those who treat veterans and their families, along with those that generate policy for the treatment of veterans.

REFERENCES:

1. Gordon, D, Therapeutic Metaphors. META Publications, 1978.
2. Van Der Kolk, BA, Traumatic Stress: The theraputic environment and new explorations in the treatment of post-traumatic stress disorder. Guilford Press, 1996.

Innovative Program 9 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

TREATMENT ADHERENCE PROGRAM

Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Describe how to intervene in factors contributing to medication adherence; 2.) Explain how information technology can be used to assist practitioners in facilitating patient adherence to treatment; and 3.) Differentiate adherence interventions with evidence-based outcomes efficacy from those without.

SUMMARY:

The main objective of the Treatment Adherence Program (TAP) Pilot Project is: Improve medication adherence for patients being treated for schizophrenia and bipolar illnesses in the State of Missouri. The primary tactics include: Selecting the right patients for continuous monitoring of medication adherence – analyze the prescription medication history of all persons using antipsychotic medications seeking patients with reoccurring patterns of partial compliance (late or inconsistent refilling), as well as total medication discontinuance. A Discontinuation Alert Call Center – a professional call center that will outreach with direct telephone calls only to providers (physicians of record and/or case managers) when analysis of medication history indicates that their patient is late refilling or might have discontinued their antipsychotic medication and/or other essential medications. An educational program for case managers – educational training sessions focused on antipsychotic prescribing, implications of medication side effects, reasons for medication discontinuation and key messages that case managers can share with their patients to motivate them to maintain treatment. An educational, user-friendly brochure for physicians – a concise brochure with current best practice guidelines on partial compliance, medication discontinuation, medication adherence tactics, patient motivation methods.

REFERENCES:

1. Centorino F, Hernan M.A., Drago-Ferrante G., et.al. (2001). Factors Associated With Non-Compliance With Psychiatric Outpatient Visits. Psychiatric Services, Vol.52(3), 378–380.
2. Day JC, Bentall RP, Roberts C,et al.(2005) Attitudes toward Antipsychotic Medication: The Impact of Clinical Variables and Relationships with Health Professionals. Archives of General Psychiatry, Vol. 62(7), 717–724.

INNOVATIVE PROGRAMS: SESSION 4

RECOVERY IN PENNSYLVANIA

Innovative Program 10 **Friday, October 12 8:00 a.m.-9:30 a.m.**

PENNSYLVANIA'S HOSPITAL TO COMMUNITY INTEGRATION PROGRAM: 1991–2007

Edna McCutcheon, M.S.W., *Chief Executive Officer, Torrance State Hospital, Torrance, PA 15779-9999*; Andrea Kepler, M.S.W., *Director, Community Resource Team, Pennsylvania Department of Public Welfare, P.O. Box 2675, Harrisburg, PA 17105-2675*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to: 1.) Define the significant change Pennsylvania's Community to Hospital Integration Project Programs (CHIPP's) has had on supporting people with long-term state hospitalizations in less restrictive community-based settings; 2.) Describe the process used in working with county and local provider groups in making this change occur; and 3.) Assess the state and county government funding process used to make this systems change occur.

SUMMARY:

During the period 1991 through 2006 more than 2,600 people served by the Pennsylvania state hospital system have been discharged to less restrictive community-based programs and services. This change has enabled the consolidation/closure of six state hospitals and infused more than 100 million state dollars into county-based mental health programs. With the closure of Harrisburg State Hospital in January 2006, state government created the Community Resource Team who is responsible for working with county and local mental health agencies to monitor and respond to the needs of people discharged from this large state hospital and assure their successful community adjustment. This innovative program will detail the process used, the partners involved, and funding strategies applied to make this statewide transformation occur.

REFERENCES:

1. The Community-Hospital Projects Program, Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services. http://www.dpw.state.pa.us/Family/Mental Health-Serv/003670497.htm.

2. Preventing Discrimination Against People with Disabilities in Health Care and Social Services. The United States Department of Health and Human Services. http://www.hhs.gov/ocr/mis.htm.

Innovative Program 11 **Friday, October 12 8:00 a.m.-9:30 a.m.**

THE RECOVERY APPROACH IN PENNSYLVANIA'S STATE HOSPITAL SYSTEM

Gregory M. Smith, M.S., *Chief Executive Officer, Department of Administration, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Edna McCutcheon, M.S.W., *Chief Executive Officer, Torrance State Hospital, Torrance, PA 15779-9999*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to: 1.) Describe the many different Recovery related activities in effect within Pennsylvania's state hospital system and the effect they have had on each hospitals service area; and 2.) Recognize that most of these changes can be both low cost and high yield while having a dramatic affect on the people who live and work within their hospital communities.

SUMMARY:

Starting in 1997, Pennsylvania's state hospital system, one of the oldest in the county and with help from the advocacy community, challenged its system of care to become more person-centered in its approach to the care and services to people with serious mental illnesses. This change affected everything from the use of restrictive procedures to the discharge planning process for people with extended hospitalizations. This continuing change has had a lasting effect of the Commonwealth's mental health service delivery system. This innovative program will detail the many different recovery-oriented approaches in effect within the various state hospitals.

REFERENCES:

1. Anthony WA: A recovery-oriented service system: setting some system level standards. Psychiatric Rehabilitation Journal 24:159–8, 2000.
2. Davidson L, O'Connell M, Tondora J, et.al: The top ten concerns about recovery encountered in mental health transformation. Psychiatric Services 57:640–645, 2006.

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

PENNSYLVANIA'S SECLUSION AND RESTRAINT REDUCTION PROGRAM: 1990–2007

Gregory M. Smith, M.S., *Chief Executive Officer, Department of Administration, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Donna M. Ashbridge, R.N., M.S., *Chief Executive Officer, Danville State Hospital, 200 State Hospital Drive, Danville, PA 17821-9198*

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should understand the dramatic reduction in the use of all restrictive procedures (restraint, seclusion and unscheduled psychiatric medications) within Pennsylvania's state hospital system and the methods and techniques used to accomplish this change.

SUMMARY:

From 1990 to 2007 the Pennsylvania state hospital system has decreased its use of seclusion and restraint by more than 99%. Currently, five of the eight state hospitals no longer permit the use of seclusion and one hospital has totally eliminated the use of seclusion and mechanical restraint. Floor control physical restraint techniques, (prone or supine restraint), are no longer permitted in the state hospitals. In March 2005, the hospital system discontinued the psychiatric use of PRN orders. This innovative program will detail the actions taken by the hospital system during this span to affect this change including historical data on incidents of patient-to-patient and patient-to-staff assaults.

REFERENCES:

1. Smith G, Davis, R, Bixler E, et.al: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program: Psychiatric Services 56:1115–1122, September 2006.
2. Hardenstine, B: Leading the way toward a seclusion and restraint-free environment, Pennsylvania's success story. Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, Harrisburg, PA. 2001.

INNOVATIVE PROGRAMS: SESSION 5

INNOVATIVE RESPONSES TO KATRINA
OMNA on Tour in the Gulf Coast Track

Innovative Program 13 **Friday, October 12**
1:30 p.m.-3:00 p.m.

PROVIDING EMOTIONAL SUPPORT TO THE RESIDENTS OF THE 9TH WARD DURING THE "LOOK AND LEAVE" PROGRAM IN NEW ORLEANS AFTER KATRINA
OMNA on Tour in the Gulf Coast Track

Elliott Hill, L.C.S.W., BCD, *Consultant, E. Hill & Associates, LLC, 2221 Peachtree Road, Suite D-178, Atlanta, GA 30309*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1.) Recognize the need for cultural orientation to volunteer teams as preparation for placements; 2.) Identify how race, economics, and stereotypes affect volunteer teams who work in crisis situations; and 3.) Describe wellness strategies for disaster responders on a cruise ship or other homogenous cramped living arrangement.

SUMMARY:
The "9th Ward" of New Orleans was one of the most flooded areas of the City after Katrina. The residents of this community were largely African American homeowners with strong ties to their neighborhood. The City denied any access to this area because of the large scale destruction and many dangerous conditions, such as physically fragile, downed utility wires, and mold growth. The City of New Orleans Homeland Security was in overall command of a program called "Look and Leave," which began two months after Katrina. The program required former residents to check in at a central staging site and ride tour buses through their neighbor hood. The reaction of the residents was a mix between anger and shock as they looked at the extreme devastation. A coordinated effort was made by mental health volunteer groups from SAMHSA, the Red Cross, and the Salvation Army and others to provide emotional support and be present with the residents of the 9th Ward as they participated in the "Look and Leave" program.

REFERENCES:
1. Nader, Kathleen; Dubrow, Nancy; Stamm, Beth Hudnall (ed.) — Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss — Philadelphia: Brunner/Mazel, 1999.
2. Webb, Nancy Boyd (ed.):Play Therapy with Children in Crisis: Individual, Group, and Family Treatment, 2d ed. — New York: Guilford Press, 1999—xxi, 506 pp.

Innovative Program 14 **Friday, October 12**
1:30 p.m.-3:00 p.m.

IMMEDIATE IMPACT: THE ROLE OF A FREE VOLUNTEER STAFF NEIGHBORHOOD HEALTH CLINIC AFTER KATRINA
OMNA on Tour in the Gulf Coast Track

Mark H. Townsend, M.D., *Professor of Psychiatry, Louisiana State University Health Sciences Center at New Orleans, 3450 Chestnut Street, Third Floor, New Orleans, LA 70115*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1.) Recognize the need for cultural orientation to volunteer teams as preparation for placements; 2.) Identify how race, economics, and stereotypes affect volunteer teams who work in crisis situations; and 3.) Describe wellness strategies for disaster responders on a cruise ship or other homogenous cramped living arrangement.

SUMMARY:
Non-governmental organizations are having a large role in the rebuilding of New Orleans. The Esplanade Ridge neighborhood was completely flooded and is miles from brick-and-mortar mental health centers and other clinics. This innovative program will recount Dr. Townsend's experience as clinical director of a free clinic that has operated in the neighborhood since the fall of 2005.

REFERENCES:
1. Monahon, Cynthia. Children and Trauma: A Parent's Guide to Helping Children Heal New York: Lexington Books. 1993.
2. Webb, Nancy Boyd (ed.) — Play Therapy with Children in Crisis: Individual, Group, and Family Treatment, 2d ed. — New York: Guilford Press, 1999—xxi, 506 pp.

Innovative Program 15 **Friday, October 12 1:30 p.m.-3:00 p.m.**

LIVING ON A CRUISE CHIP AND ATTENDING TO THE EMOTIONAL WELLBEING OF THE CHILDREN OF DISASTER PERSONNEL AFTER KATRINA

OMNA on Tour in the Gulf Coast Track

Mary Ann Abney, APRN, BC, *Advanced Practice Registered Nurse, and Board Certified Clinical Nurse Specialist in Child, Adolescent, and Adult Mental Health Nursing, 57 Meetinghouse Lane, Brattleboro, VT 05301*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Recognize the need for cultural orientation to volunteer teams as preparation for placements; 2.) Identify how race, economics, and stereotypes affect volunteer teams who work in crisis situations; and 3.) Decribe wellness strategies for disaster responders on a cruise ship or other homogenous cramped living arrangement.

SUMMARY:

The trauma that occurs during and after a natural disaster is difficult for adults to comprehend and sometimes more difficult to begin to consider their own wellness and the wellness of their children. Working with children of Disaster Recovery Personnel in post-disaster environments is a necessary component of holistic wellness.

REFERENCES:

1. Gray BH; Hebert K; Hospitals in Hurricane Katrina: Challenges Facing Custodial Institutions in a Disaster. J Health Care Poor Underserved; 18(2):283–298, 2007 May.
2. Kirkpatrick DV; Bryan M; Hurricane Emergency Planning by Home Health Providers Serving the Poor. J Health Care Poor Underserved; 18(2):299–314, 2007 May.

Innovative Program 16 **Friday, October 12 1:30 p.m.-3:00 p.m.**

ENGAGING THE FAITH-BASED COMMUNITIES AND USING A SPIRITUAL COUNSELING PERSPECTIVE AS VOLUNTEER CRISIS WORKER

OMNA on Tour in the Gulf Coast Track

Richard Thomas, Psy.D., *Pastoral Psychotherapist, P.O. Box 13327, Greensboro, NC 27415*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Recognize the need for cultural orientation to volunteer teams as preparation for placements; 2.) Identify how race, economics, and stereotypes affect volunteer teams who work in crisis situations; and 3.) Describe wellness strategies for disaster responders on a cruise ship or other homogenous cramped living arrangement.

SUMMARY:

Traditionally when we think about mental health crisis work, the significance of a pastoral counselor may be overlooked. Individual's spiritual beliefs can be a powerful source of strength during a time of crisis. This presentation will explain how a psychologist and spiritual counselor was able to: 1.) Approach churches in New Orleans; and 2.) Offer counseling to local mental health staff personnel and his team member as they helped others.

REFERENCES:

1. Guide Helps Disaster Responders Apply Stress-Related First Aid: Psychiatric News, October 7, 2005 Volume 40, Number 19, page 9. American Psychiatric Association.
2. Vance RE, The role of the spiritual counselor in times of crisis; Nursing Homes, September 1997.

Innovative Program 17 **Friday, October 12 1:30 p.m.-3:00 p.m.**

LIVING ON A CRUISE SHIP AND ATTENDING TO THE EMOTIONAL WELLBEING OF DISASTER PERSONNEL AFTER KATRINA

C. Philip Johnson, *Certified Addictions Specialist, 33 K Street, N.W., Washington, DC 20001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the praticipant should be able to: 1.) Recognize the need for cultural orientation to volunteer teams as preparation for placements; 2.) Identify how race, economics, and stereotypes affect volunteer teams who work in crisis situations; and 3.) Describe wellness strategies for disaster responders on a cruise ship or other homogenous cramped living arrangement.

SUMMARY:

In New Orleans, Katrina destroyed many of the homes and other housing options for the majority of key disaster recovery personnel. In response to this housing shortage, many of the Katrina first responders, City Administrators, police personnel, military, and rescue personnel,

and their families lived on cruise chips that were docked in the downtown area. This presentation will illustrate how volunteer teams provide wellness to the responders and their families.

REFERENCES:

1. Lawrence B. Rosenfeld, Joanne S. Caye, Ofra Ayalon, and Mooli Lahad; When Their World Falls Apart: Helping Families and Children Manage the Effects of Disasters, 2004.
2. Guide Helps Disaster Responders Apply Stress-Related First Aid: Psychiatric News, October 7, 2005, Volume 40, Number 19, page 9, American Psychiatric Association.

INNOVATIVE PROGRAMS: SESSION 6

RECOVERY APPROACHES FOR CHALLENGING POPULATIONS

Innovative Program 18 **Friday, October 12 3:30 p.m.-5:00 p.m.**

COMMUNITY FORENSIC SERVICES: AN INTEGRATED MODEL OF CLINICAL CARE FOR FORENSIC CLIENTS

Sarah M. DeLand, M.D., *Department of Psychiatry and Neurology, Tulane Health Sciences Center, 1440 Canal Street, TB- 53, New Orleans, LA 70112-2703*; John Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Describe a service model for the provision of community-based forensic psychiatric services; 2.) Recognize the demographic and clinical characteristics of forensic clients in the community; and 3) List the challenges facing forensic practitioners.

SUMMARY:

Community forensic mental health teams typically adopt either an integrated or parallel model of service delivery (Mohan et.al., 2004). Community Forensic Services (CFS) is a stand-alone program created within the Louisiana Office of Mental Health and integrated with community mental health centers to provide wrap-around clinical and case management services to forensic clients. The goal of CFS is to provide a cost-effective alternative to inpatient hospitalization. CFS has two primary areas of responsibility: 1.) A jail-based competency restoration program for pre-trial criminal defendants; and 2.) Community monitoring and the provision of ancillary services to clients in conditional release programs (CONREPs). The structure of CFS is unique in that Forensic Service Teams (FSTs), comprised of a district forensic coordinator and a forensic psychiatrist, provide monitoring and clinical services and function as a safety net for clients. In New Orleans, where over 40% of the discharged/diverted forensic clients reside, CFS operates a specialized aftercare clinic, the Forensic Aftercare Clinic (FAC). FAC utilizes a parallel model whereby clients have access to round-the-clock psychiatric, rehabilitative, and supervisory services. Data from these programs demonstrate that forensic clients can be effectively monitored in the community and provide a much needed alternative to long-term psychiatric hospitalization.

REFERENCES:

1. Mohan, Rajesh, Slade, Mike, Fahy, Tom A. Clinical Characteristics of Community Forensic Mental Health Services; Psychiatric Services, 2004 55: 1294–1298.
2. LJ Bertman-Pate, DMR Burnett, JW Thompson, CJ Calhoun, S Deland, & R Mark Fryou (2004); The New Orleans Forensic Aftercare Clinic: A Seven Year Review of Hospital Discharged and Jail Diverted Clients. Behavioral Sciences and the Law, 22, 159–69.

Innovative Program 19 **Friday, October 12 3:30 p.m.-5:00 p.m.**

THE ADVANTAGES OF PORTABLE TELEMEDICINE

Jose E. Nieves, M.D., *Department of Psychiatry, Veterans Administration/Eastern Virginia Medical School, 203 Fairfield Drive, Yorktown, VA*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Identify at least two limitations of videoconferencing in psychiatry; and 2.) Recognize two videophone clinical applications.

SUMMARY:

Telehealth in psychiatry continues to gain widespread use, but some barriers remain. Videoconferencing is usually the preferred equipment in mental health. At 384 kbits/sec this option provides a high resolution image. It is used for medication management, individual, family and group therapy. However, it requires dedicated space, specialized lines, technical support and because of their size, have limited mobility. These factors can limit utilization and access, the most compelling reasons to use telehealth are: 1.) Videophones provide a novel alternative in telemental health; and 2.) While their image size is small and restricted to a 24–56 Kbits/sec transmission speed, its portability, durability, low cost and ease to

use make up for these limitations. This bandwidth may be sufficient for simple psychiatric follow-up medical consultations, care taker discussions or community case management medical access. They are also an effective medium to introduce medical students and residents to other telehealth concepts in addition to clinical practice. Liability, privacy, remote lightning, verbal and non-verbal communication can be demonstrated and taught easily to young clinicians through videophone equipment. Videophones provide a reasonable alternative for some clinical and teaching applications when mobility, cost, and technical support are limits to deployment.

REFERENCES:

1. Rothchild, E. Telepsychiatry, Why Do It, Psychiatric Annals, Vol. 29, July 1999, pages 394–401.
2. Nieves, J.E., Videophones and Psychiatry, Clinical Psychiatric News, Vol. 34, #3, page 22.

Innovative Program 20 **Friday, October 12 3:30 p.m.-5:00 p.m.**

CLUBHOUSE AND PSYCHIATRY FOR EMPLOYMENT

Ralph Aquila, M.D., *Director, Residential Community Services, Project Renewal, and Department of Psychiatry, St. Luke's/Roosevelt Hospital Center, 167 Upper Mountain Avenue, Montclair, NJ 07042*; Thomas A. Malamud, M.A., *Rehabilitation Counselor, Center for Reintegration and Special Projects, 350 A West 49th Street, New York, NY 10019*; Robert Scholer, A.A., *Rehabilitation Counselor, Project Renewal, 448 West 48th Street, New York, NY 10036*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe how employment can impact the person in recovery and their immediate system.

SUMMARY:

Much has been said about the implementation of a multidisciplinary team, but little has been shown how this team achieves employment, in particular good paying jobs. This session will attempt to show how psychiatric treatment, combined with a clubhouse working in a nearby storefront, can accomplish this goal. In particular, looking at the belief system that persons in recovery from serious mental illness can achieve and be successful in their jobs.

REFERENCES:

1. The Rehabiliation Allianc in Practice: The Clubhouse Connection. Ralph Aquila M.D., George Santos, Thomas J. Malamud, Dennis McCrory M.D. Psychiatric Rehabiliation Journal, Vol.23, Number 1, Summer 1999.
2. Supported Employment Outcomes of a Randomized Controlled Trial of ACT and Clubhouse Models Macias, Cathleen Rodican Charles, Hargreaves, William, Barriera, Paul, Qi Wang; Psychaitric Services, October 2006, Vol.57, No. 10.

INNOVATIVE PROGRAMS: SESSION 7

RESPONSE TO TRAUMA

Innovative Program 21 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

RENEWING COMMUNITY PSYCHIATRY IN NEW ORLEANS: REPORTS FROM THE FIELD

Mark H. Townsend, M.D., *Professor of Psychiatry, Louisiana State University Health Sciences Center at New Orleans, 3450 Chestnut Street, Third Floor, New Orleans, LA 70115*; Jose Calderon, M.D., *Assistant Professor of Psychiatry, Louisiana State University Health Sciences Center at New Orleans, 210 State Street, New Orleans, LA 70115*; Erich J. Conrad, M.D., *Assistant Professor of Psychiatry, Louisiana State University Health Sciences Center at New Orleans, 1028 Joseph Street, New Orleans, LA 70115*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the effects of Hurricane Katrina on public psychiatry in New Orleans and the effort to restore it.

SUMMARY:

The catastrophic flooding caused by Hurricane Katrina irrevocably changed public psychiatry in New Orleans and the surrounding region. Charity Hospital's large psychiatric emergency room and 92 inpatient beds were closed, and schools and clinics were destroyed throughout the metropolitan area. The entire city was evacuated and closed to civilians for several weeks, and reopened only in stages. Our panelists, all faculty at the Louisiana State University Health Sciences Center, New Orleans, will discuss the successes and setbacks they encountered in helping to reestablish four key areas of public health: acute inpatient psychiatry; community-based child and adolescent services; emergency psychiatry; and adult outreach programs. We will discuss the novel situations and practices inherent in redeveloping accreditably services in a region depleted of resources by unprecedented natural disaster.

REFERENCES:

1. Weisler RH, Barbee JG, Townsend MH. Mental Health and recovery in the Gulf Coast after Hurricanes Katrina and Rita. JAMA 2006;296:585–8.
2. Kessler RC, Sandro G, Jones RT, Parker HH. Mental illness and suicidality after Hurricane Katrina. Bulletin of the World Health Organization, in press.

Innovative Program 22 Saturday, October 13 10:00 a.m.-11:30 a.m.

PLANNING FOR TREATMENT OF PATIENTS WITH SERIOUS MENTAL ILLNESS: LESSONS FROM KATRINA

American Association of Community Psychiatrists

Jeffrey G. Stovall, M.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 72 Jaques Avenue, Worcester, MA 01610-2476*; Christopher Colihan, *Sales Representative, Teva Pharmaceuticals, 1090 Horsham Road, North Wales, PA 19454-1090*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate a knowledge of potential needs of people with serious mental illness following a disaster, with a focus on the continued use of clozapine, and recognize potential obstacles to continuing the drug treatment.

SUMMARY:

Events following a natural disaster are chaotic, even more so for an individual with serious mental illness. Potentially disconnected from essential social services and medications, a person with a serious mental illness may have rapidly dwindling resources with which to care for themselves. This presentation will focus on the aftermath of Hurricane Katrina and the delivery of the gold standard antipsychotic drug Clozapine in the weeks that followed. A representative of Teva Pharmaceuticals will discuss the efforts of the primary supplier of Clozapine to continue providing medication to patients, and to coordinate with psychiatrists and relief programs. The presenters will use this experience to discuss planning for future disasters, emphasizing planning for people with serious mental illness. The presentation will be of interest to psychiatrists working with people with serious mental illness, and to administrators and managers who may plan for disaster efforts.

REFERENCES:

1. Lieberman J, Stroup TS, McEvoy J, et.al: Effectiveness of antipsychotic drugs in patients living with chronic schizophrenia. New England Journal of Medicine, 22 (353), 1209–1223.
2. Saving lives: including people with disabilities in disaster planning. National Council on Disability. April 2005, www.ncd.gov.

Innovative Program 23 Saturday, October 13 10:00 a.m.-11:30 a.m.

TRAUMA REFRAMING THERAPY: GROUP PSYCHOEDUCATION FOR TRAUMA RECOVERY

Mary Moller, M.S.N., D.N.P., *Doctor of Nursing Practice, and Advanced Registered Nurse Practitioner, Suncrest Wellness Center, 9103 N. Division Street, Lower Level, Spokane, WA 99218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe a 12-week, mixed gender group psychoeducational model that focuses on a wellness approach to trauma recovery.

SUMMARY:

Traumatic experiences can cause alterations in health, attitudes and behaviors, environmental and interpersonal functioning, and spiritual balance. The 'Be Smart' (Become Empowered: Symptom Management for Abuse and Recovery from Trauma) group psychoeducation program is a 12-week course designed for both men and women to learn wellness coping principles in recovering from the aftermath of trauma and abuse. The course is based on the Murphy-Moller Wellness Model (1996) and Trauma Reframing Therapy (Rice & Moller, 2003). A program evaluation study of ten males age 20–65 and 44 females age 20–66 was conducted to determine if the ''Be Smart'' course would improve wellness scores in subjects with trauma-related disorders. Levels of wellness were evaluated using the Wellness Assessment Tool (Murphy & Moller, 1996) that evaluates ten wellness components in the four domains of : health, attitudes/behavior, environment/relationship, and spirituality. Paired sample correlations showed statistically significant correlations between 37 of the 50 pairs, ranging from .524 in the health scores to .830 in spirituality. Paired t tests also showed significant differences at p= .05 in each of the wellness domains. Subjects felt an improvement in overall health, a decrease in interpersonal conflict, a stronger sense of spirituality, and improvement in environmental control and interpersonal relationships.

REFERENCES:

1. Moller MD & Rice MJ: The 'Be Smart' trauma reframing psychoeducation program. Archives of Psychiatric Nursing 2006; 20: 21–31.

2. Rice MJ & Moller MD: Wellness outcomes of group psychoeducation on trauma and abuse. Archives of Psychiatric Nursing 2006; 20: 94–102.

INNOVATIVE PROGRAMS: SESSION 8

KICKING THE HABIT: RECOVERING FROM TOBACCO DEPENDENCE

Innovative Program 24 Saturday, October 13 1:30 p.m.-3:00 p.m.

USING PEER COUNSELORS TO ADDRESS TOBACCO: THE CHOICES PROGRAM

Jill Williams, M.D., *Associate Professor of Psychiatry, UMDNJ-Robert Wood Johnson Medical School, 317 George Street, Suite 210, New Brunswick, NJ 08901–2008*; Martha Dwyer, M.A.; Marie Verna; Margaret Molnar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss an innovative consumer driven model for addressing tobacco in mental health settings, including the advantages of a consumer driven approach.

SUMMARY:

Tobacco dependence is a tremendous problem for mental health consumers. The CHOICES program has a unique consumer-driven perspective for addressing tobacco and is a partnership between UMDNJ-RWJMS, the Mental Health Association in New Jersey and the NJ State Division of Mental Health Services. CHOICES stands for Consumers Helping Others Improve their Condition by Ending Smoking and employs mental health peer counselors to deliver the message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment. These Consumer Tobacco Advocates (CTAs) serve as tobacco-focused consultants to assist with linkages to treatment, referrals, advocacy, support and the provision of educational materials. CHOICES CTAs participate in intensive training to learn how to discuss tobacco issues with peers, and organize activities like health fairs and smoke-outs. The CHOICES program distributes a quarterly newsletter, mailed free to consumers. Consumers submit articles and art to the newsletter, which also incorporates information on tobacco education and treatment (www.njchoices.org). Since inception, one year ago, CHOICES has made more than 84 on-site visits to community sites interacting with more than 2,040 consumers who smoke. Feedback from smokers about the program is positive and CHOICES can serve as a model for other states.

REFERENCES:

1. Williams JM and Ziedonis DM. Addressing Tobacco among Individuals with a Mental Illness or an Addiction. Addictive Behaviors 2004; 29(6):1059–1270.
2. Steinberg, ML, Ziedonis, DM, Krejci, JA, Brandon, TH. Motivational Interviewing With Personalized Feedback: A Brief Intervention for Motivating Smokers With Schizophrenia to Seek Treatment for Tobacco Dependence. Journal of Consulting and Clinical Psychology 2004; 72(4): 723–728.

Innovative Program 25 Saturday, October 13 1:30 p.m.-3:00 p.m.

MOTIVATING THOSE WITH ADDICTIONS TO QUIT SMOKING: IT CAN BE DONE

Kathleen M. Stack, M.D., *Staff Psychiatrist and Assistant Clinical Professor, Department of Veterans Affairs/ Eastern Virginia Medical School, 100 Emancipation Drive, #18, Hampton, VA 23667*; James Goalder, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Demonstrate at least three strategies to increase motivation to cut back or quit smoking in difficult populations; and 2.) Utilize at least three new resources to assist addicted patients to quit smoking.

SUMMARY:

The catastrophic flooding caused by Hurricane Katrina irrevocably changed public psychiatry in New Orleans and the surrounding region. Charity Hospital's large psychiatric emergency room and 92 inpatient beds were closed, and schools and clinics were destroyed throughout the metropolitan area. The entire city was evacuated and closed to civilians for several weeks, and reopened only in stages. Our panelists, all faculty at the Louisiana State University Health Sciences Center, New Orleans, will discuss the successes and setbacks they encountered in helping to reestablish four key areas of public health: acute inpatient psychiatry; community-based child and adolescent services; emergency psychiatry; and adult outreach programs. The presenters will discuss the novel situations and practices inherent in redeveloping accreditably services in a region depleted of resources by unprecedented natural disaster.

REFERENCES:

1. Weisler RH, Barbee JG, Townsend MH. Mental health and recovery in the Gulf Coast after Hurricanes Katrina and Rita. JAMA 2006;296:585–8.
2. Kessler RC, Sandro G, Jones RT, Parker HH. Mental illness and suicidality after Hurricane Katrina. Bulletin of the World Health Organization, in press.

Innovative Program 26 Saturday, October 13 1:30 p.m.-3:00 p.m.

CHANGING THE MENTAL HEALTH SYSTEM TO INTEGRATE TOBACCO DEPENDENCE TREATMENT

Bernadette Cain, M.B.A., *Training Consultant, Clubhouse of Suffolk, Inc., Tobacco and Mental Health Training Project, 939 Johnson Avenue, Ronkonkoma, NY 11779*; Jill Williams, M.D., *Associate Professor of Psychiatry, UMDNJ-Robert Wood Johnson Medical School, 317 George Street, Suite 210, New Brunswick, NJ 08901-2008*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Describe how changes within the mental health systems will support the success of cessation attempts by individuals; 2.) Explain the role of mental health professionals in treating tobacco dependence; and 3.) Evaluate a systems change model for addressing tobacco in mental health systems developed by faculty at UMDNJ.

SUMMARY:

Tobacco use is a major problem for individuals with serious mental illness (SMI). About 70% of this population is smokers, and many will die from tobacco-caused diseases. Smokers with SMI have reduced access to cessation services in the community, and integrated models for tobacco treatment within the mental health system have advantages. This innovative program will target administrators, policy makers, practitioners, students and educators for a discussion of strategies for culture and practice change within the mental health system for the integration of tobacco treatment services. Our learning objectives will be addressed through the presentation of three components of tobacco treatment integration: 1.) The video ''Smoke Alarm: The Truth About Smoking and Mental Illness'', which features five mental health consumers, will be used to communicate the latest statistics regarding tobacco use among the seriously mentally ill, as well as showcase consumer stories and self-reports regarding their struggle with tobacco addiction and mental illness; 2.) Bernadette Cain, M.B.A. (presenter 1) will discuss the tobacco dependence intervention model for a Clubhouse; and 3.) Jill Williams, M.D. (presenter 2) will discuss the Systems Change Model developed by faculty at the University of Medicine and Dentistry in New Jersey.

REFERENCES:

1. Williams JM, Cain BW, Fredericks T, O'Shaughnessy M. A Tobacco Treatment Model for Individuals with Serious Mental Illness. Psychiatric Services 2006; 57(8): 1210.
2. Williams JM and Ziedonis DM. Addressing Tobacco among Individuals with a Mental Illness or an Addiction. Addictive Behaviors 2004; 29(6): 1059–1270.

INNOVATIVE PROGRAMS: SESSION 9 NOVEL PROGRAMS FOR PEOPLE WITH SUBSTANCE ABUSE DISORDERS

Innovative Program 27 Saturday, October 13 3:30 p.m.-5:00 p.m.

THE TAKING INITIATIVE CENTER: AN INNOVATIVE OUTREACH AND SERVICES PROGRAM FOR HOMELESS PERSONS WITH SUBSTANCE USE DISORDERS

Thomas H. Styron, Ph.D., *Associate Professor of Psychiatry, Yale University School of Medicine, 34 Park Street, Room 144, New Haven, CT 06519*; Allison N. Ponce, Ph.D., *Assistant Professor of Psychiatry, Yale University School of Medicine, 34 Park Street, Room 144, New Haven, CT 06519*; Deborah A. Fisk, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should obtain useful knowledge with regard to an innovative homeless outreach program and the people it serves.

SUMMARY:

The Taking Initiatives Center (TIC), located in downtown New Haven, Connecticut, is a community-based, multi-agency initiative designed to engage homeless persons with substance use issues, who are still using, trying to stop, or in the early stages of recovery. The aim of the program is to engage, motivate and support those served, so that they can adopt a healthy daily routine, gain employment, and reconnect with lost relationships and opportunities.Unlike many other programs that work with people who are homeless, TIC has no exclusionary criteria around substance use that would bar someone from receiving services. TIC is open seven days a week and no referrals are necessary. TIC provides members with breakfast and lunch, free laundry facilities, showers, phone use, and three computers. There are also life skills, AA/NA, and meditation groups, and on-site medical care. Case coordinators provide referrals to employment services and psychoeduction, with transportation available to and from shelters. TIC also has gender-specific and trauma-informed engagement services to help homeless women transition into substance abuse treatment. Approximately 750 individuals have utilized TIC since

its doors opened in 2001. Outcome data will be presented.

REFERENCES:

1. Tommasello A.C., Myers C.P., Gillis L., Treherne L.L., Plumhoff M. Effectiveness of outreach to homeless substance abusers. Evaluation and Program Planning. 22 (3), 295–303(9), 1999.
2. Rowe, M., Fisk, D., Frey, J., Davidson, L. Engaging Persons with Substance Use Disorders: Lessons from Homeless Outreach. Administration and Policy in Mental Health Services, 29(3), 263–273, 2002.

Innovative Program 28 Saturday, October 13 3:30 p.m.-5:00 p.m.

OUTCOMES OF ANTI-SMOKING INTERVENTIONS IN RESIDENTIAL SUBSTANCE ABUSE TREATMENT

Kathleen M. Stack, M.D., *Staff Psychiatrist and Assistant Clinical Professor, Department of Veterans Affairs/ Eastern Virginia Medical School, 100 Emancipation Drive, #18, Hampton, VA 23667*; Erica L. Bradshaw, M.D.; James Goalder, Ph.D.; Carl Samples, B.A.; Patrick Calhoun, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that anti-smoking efforts should be initiated concurrently with other addictions.

SUMMARY:

Objective: To increase the rates at which those in substance abuse treatment cut back and quit smoking.

Methods: Number of cigarettes smoked was obtained by self-report at admission and discharge. Smoking habits of staff were also recorded year 1, smoking areas were limited and smoking in non-designated areas involved treatment team intervention. Smoking was added on Axis I, problem list and treatment plan. Attendance at smoking cessation classes (SSC) was documented. Year 2, continues year 1 with addition of four, one-hour classes (SCC) designed to remove obstacles and increase motivation to quit. Classes were dynamic and interactive.

Results: year 1: 194/241 (80%) smoked. 78/1 (40%) participated in SCC, 12 (15%) quit smoking, 41 (53%) cut back an average of 10 and 25 (32%) had no change. Year 2: 2/193 (84%) smoked. 104 (64%) participated in SCC, 27/104 (26%) quit smoking, 53/104 (51%) cut back an average of 11 and 24/104 (23%) had no change. The motivation course in year 2 was associated with increased SCC attendance (40% vs. 64%) p<.001 and an increase in the percentage of patients who either cutback or quit (40% vs. 52%) p=.025. Attendance at SCC was associated with increased rates of quitting (p<.001) and cutting back (p<.001). Unwillingness to attend SCC was associated with increased irregular discharges (p<.001). 7/13 staff were lifetime non-smokers, 4 were former smokers and 2 were intermittent smokers.

Conclusions: Efforts to increase motivation to quit smoking can lead to improvements even in this difficult population who are not often encouraged to quit. Additionally non-attendance was associated with a higher rate of irregular discharge in smokers.

REFERENCES:

1. Joseph, A.M. (1993). Nicotine treatment at the drug dependency program of the Minneapolis VA Medical Center. Journal of Substance Abuse Treatment, 10, 147–52; 1993.
2. Stotts, A.L., Schmitz, J.M. Concurrent treatment for alcohol and tobacco dependence: are patients ready to quit both? Drug and Alcohol Dependence, 69, 1–7; 2003.

Innovative Program 29 Saturday, October 13 3:30 p.m.-5:00 p.m.

THE BENEFITS OF SUBSIDIZED SOBER HOUSING FOR HOMELESS PERSONS

Deborah A. Fisk, L.C.S.W., *Director, Outreach and Engagement, Connecticut Mental Health Center, 235 Nicholl Street, New Haven, CT 06515*; Kathleen A. DeMino, D.S.W., *Family Therapy Consultant, Crossroads, Inc., 41 Maplehurst Road, Guilford, CT 06437*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Discuss the need for assertive programs to engage homeless persons with addiction disorders into services; 2.) Recognize the benefit of sober housing for homeless persons; and 3.) Describe the benefit of using housing subsidies for persons with addiction disorders at higher stages of the motivational continuum.

SUMMARY:

Substantial evidence points to the need for innovative programs to serve homeless persons with addiction disorders. The Treatment Access Project (TAP) provides rental subsidies for homeless people with substance abuse disorders to reside in sober houses in early stages of their recovery, thus offering several advantages. First, the program itself provides an incentive to treatment for certain homeless addicted individuals. Second, it affords individuals the opportunity to move from residential treatment to a sober environment without returning to homeless shelters. Third, it affiliates individuals with others who are in recovery. Finally, it provides a respite in which individuals can attend to their recovery as they

transition back into the workforce and rebuild social networks. Once connected to other sober individuals and employed, these individuals have an enhanced opportunity to retain sobriety and housing. Project clients who were admitted to the program at higher phases of the motivational continuum are more likely to discharge with a positive status; sober and housed at six months after entry into the program. This suggests that providing subsidies for sober housing to individuals at higher stages of treatment readiness can support homeless persons with substance abuse disorders attain and maintain sobriety and permanent housing.

REFERENCES:

1. Fisk, D., Rakfeldt, J., & McCormack, E. (2006). Assertive Outreach: An Effective Strategy for Engaging Homeless Persons with Substance Use Disorders into Treatment. The American Journal of Drug and Alcohol Abuse, 32, 479–486.
2. Rowe, M., Fisk, D., Frey, J., & Davidson, L (2002). Engaging persons with substance use disorders: Lessons from homeless outreach. Administration and Policy in Mental Health, 29, 263–273.

Lecture 1 — Thursday, October 11, 10:00 a.m.-11:30 a.m.

CARDIOMETABOLIC RISK IN PERSONS WITH SCHIZOPHRENIA

John W. Newcomer, M.D., *Professor of Psychiatry, Psychology, and Medicine, Washington University School of Medicine; and Medical Director for the Center for Clinical Studies, 660 South Euclid, Box 8134, St. Louis, MO 63110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the importance of cardiometabolic screening in persons with major mental disorders and utilize this information, along with treatments and other interventions to lower morbidity and mortality in this population.

SUMMARY:

Major mental disorders like schizophrenia are associated with a loss of 25–30 mean years of potential life compared to the general population, with the majority of those deaths due to premature cardiovascular disease (CVD, e.g., coronary heart disease). Schizophrenia is associated with an increased prevalence of modifiable CVD and diabetes risk factors such as overweight and obesity, smoking, hyperglycemia, hypertension and dyslipidemia, and these risk factors are commonly undertreated. Multiple factors contribute to the overall problem, including poverty, urbanization and reduced access to integrated medical care. In addition, there is substantial evidence that psychotropic medications in general and some antipsychotic medications in particular can increase weight and adiposity. Adiposity-related and adiposity–independent risk for dylipidemia and hyperglycemia is also observed with some medications. Cardiometabolic screening of individuals with major mental disorders along with the use of treatments and interventions that reduce risk can lower morbidity and mortality in this vulnerable population.

REFERENCES:

1. American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004;27(2):596–601.
2. Newcomer JW. Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive literature review. CNS Drugs. 19(1):1–93, 2005.
3. Haupt DW, Fahnestock PA, Flavin KA, Schweiger JA, Stevens A, Hessler MJ, Maeda J, Yingling M, Newcomer JW. Adiposity and insulin sensitivity derived from intravenous glucose tolerance tests in antipsychotic-treated patients. Neuropsychopharmacology. Online publication 21 March 2007.

Lecture 2 — Thursday, October 11, 1:30 p.m.-3:00 p.m.

RECOVERY IS IN THE EYE OF THE BEHOLDER

Jacqueline M. Feldman, M.D., *Vice Chairperson, APA/IPS Scientific Program Committee; Past President, American Association of Community Psychiatrists; and Patrick H. Linton Professor, Department of Psychiatry, University of Alabama at Birmingham, 908 20th Street, Suite 4 CCB, Birmingham, AL 35294*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to analyze and discuss the effects of the recovery efforts in the New Orleans area and in other countries.

SUMMARY:

Conceptualizing recovery for those with Schizophrenia requires a transformation in the culture of treatment for schizophrenia. Providers have to accept (and embrace) the possibility of recovery, enter into partnerships (versus hierarchical relationships) with their patients, and be mindful of the parameters necessary for the journey towards recovery to occur. Issues related to treatment options, adherence, choise versus control, attention to dual diagnosis and medical illnesses, and hope will be addressed.

REFERENCES:

1. Liberman, RF, Kopelowicz, A. Recovery from Schizophrenia: A concept in search of research. Psychiatric Services, 56, 2005, 735–742.
2. Warner R, Mandeberg J. Changing the Environment of Schizophrenia at the Community Level; Australian Psychiatry, 2003, 11 (Supplement 1), 558–564.

Lecture 3 — Thursday, October 11, 1:30 p.m.-3:00 p.m.

PSYCHIATRIC DIMENSIONS OF DISASTER

Health Services Research Track

Carol S. North, M.D., *Professor of Crisis Psychiatry, University of Texas Southwestern Medical Center; and Professor of Psychiatry, VA Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-7201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) List the types and prevalence of psychiatric disorders in survivors of major disasters such as the Oklahoma City bombing, and the related disaster typology and time frame of their occurrence; 2.) Critically examine elements of diagnostic criteria for PTSD and the significance of symptom types in predicting post-disaster mental health effects; 3.) Differentiate symptoms and distress from psychopathology in the post-disaster setting, and discuss the appropriate approach to these very different phenomena; and 4.) Identify predictors of psychopathology versus resilience following disasters.

SUMMARY:

This presentation will provide an overview of mental health consequences of major disasters, using empirical data from two decades of research with more than 3,000 directly exposed survivors of 15 disasters to develop and illustrate principles of post-disaster mental health assessment and intervention. Findings from the presenter's landmark study of the Oklahoma City bombing and other studies will provide hard data to support conclusions about disaster mental health effects and recommendations for disaster mental health workers. Comparison of findings from different disasters will be presented, as well as key findings from recent disasters such as 9/11, anthrax on Capitol Hill, and Hurricane Katrina. Broader issues addressing trauma typology, timing of disaster mental health recovery, confounding effects of multiple co-occuring groups-informed by the most current postdisaster conceptualizationin the post-9/11 era will also be addressed to orient post-disaster mental health efforts.

REFERENCES:

1. North CS, Nixon SJ, Shariat S, Mallonee S. McMillen JC, Spitznagel EL, Smith EM. Psychiatric Disorder Among Survivors of the Oklahoma City Bombing. Journal of the American Medical Association, *1999; 282(8):755–762.*
2. North CS, Pfefferbaum B. Research on the Mental Health Effects of Terrorism (editorial). Journal of the American Medical Association, 2002;288:633–636.

Lecture 4 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

UNDERSTANDING MAGIC: PSYCHOLOGICAL AND SOCIAL THEORIES OF MAGIC - A PERFORMANCE LECTURE

James H. Hussey, M.D., *MHR Program Director, and Associate Medical Director, Louisiana State Office of Mental Health, 5022 Alphonse Drive, Metairie, LA 70005-1005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Recognize how magicians utilize psychosocial principles to transform what we perceive as reality, and then achieve "the impossible"; 2.) Define how magicians exploit what we have learned and accepted as true and possible to create "conflicts in judgment" which result in the experience of "magic moments"; 3.) Discuss how magic has been with man from the beginning, how it speaks to human potential, helps us cope with adversity, and protects us from civilization and society's repression, helping to define man as human; 4.) Learn about the origin, prevalence and functions of superstitious behaviors in modern society; and 5.) State how theatrical magic can be used as metaphor in therapeutic situations.

SUMMARY:

This performance lecture by professional magician and board-certified psychiatrist, Jim Hussey, M.D., delves into the magical operations which define man as human. In addition to describing some of the psychological principles employed by magicians during the course of a theatrical magic performance, internal (thought) reality and external reality are explored, as are the functions of magic in modern society which speak to human potential, hope, creative thinking, and protecting the self from the restrictions imposed by civilization. Superstitious beliefs and practices are discussed, including the prevalence of such beliefs, their relationship to mental disorders, as well as ideas regarding their possible purpose and function. From Freud, Jung, Piaget and Roheim to Einstein, Keats and Kierkegaard, each of these modern thinkers understood the pervasiveness and importance of magic in modern society.

REFERENCES:

1. Aveni, Anthony, 1996, Behind The Crystal Ball, Magic From Antiquity to The New Age (Times Books).
2. Bandler, Richard & Grinder, John, 1975, The Structure of Magic, A Book About Language and Therapy (Science and Behavior Books, Inc.).

Lecture 5 **Friday, October 12 8:00 a.m.-9:30 a.m.**

REFLECTIONS ON RECOVERY

Suzanne E. Vogel-Scibilia, M.D., *President, National Alliance on Mental Illness; and Assistant Clinical Professor of Psychiatry, University of Pittsburgh School of Medicine, 219 Third Street, Beaver, PA 15009-2301*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to better diagnose and treat patients with Bipolar Disorder.

SUMMARY:

This lecture will focus on utilizing the recovery model in clinical practice by addessing stages of recovery and on applying practical principles and suggestions for clinical care of persons with SPMI. Participants will learn how to partner for consumer-focused care and encourage recovery within the traditional medical model framework.

REFERENCES:

1. Frese, Stanley, Kress, Vogel-Scibilia; IntegratingEvidence Based Practices and the Recovery Model Psychiatric Services, 2001 November 52 (11), 1462–8.
2. Book Chapter - Lefly HP and Vogel-Scibilia SE; Consumer Advocacy and Self-Help in the Psychological Treatment of Bipolar Disorder; Johnston SL, Leahy RL Guilford Press, October 2003.

Lecture 6 **Friday, October 12 10:00 a.m.-11:30 a.m.**

ELIMINATING DISPARITIES IN MENTAL HEALTH CARE: POLICY TO PRACTICE

Altha J. Stewart, M.D., *President, American Psychiatric Foundation; and President, Stewart Behavioral Health Associates, 111 South Highland, #180, Memphis, TN 38111*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Demonstrate improved awareness of cultural influences on psychiatric symptoms; and 2.) Identify strategies for incorporating the science and skills related to mental health treatment into better public health policy.

SUMMARY:

Numerous national reports have identified the problems of acheiving elimination of disparities in access to mental health care for racial and ethnic minorities. Based on strategies identified in the two reports on mental health issued by the Surgeon General (1999 and 2001), funded initiatives have been implemented, yet, the service system remains limited in its ability to achieve elimination of these disparities. Policies that direct funding and standards of care for these populations have not fully incorporated these recommendations.

REFERENCES:

1. Cross TL, Bazron BJ, Dennis KW and Isaacs MR. (1989). Towards a Culturally Competent System of Care. Washington, DC: CAASP Technical Asssistance Center.
2. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race and Ehtnicity-Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Lecture 7 **Friday, October 12 10:00 a.m.-11:30 a.m.**

BIOSOCIAL TREATMENT OF SCHIZOPHRENIA

APA/APF Alexander Gralnick Award for Research in Schizophrenia

William R. McFarlane, M.D., *Professor of Psychiatry, University of Vermont; and Director, Center for Psychiatric Research, Maine Medical Center, 315 Park Avenue, #B, Portland, ME 04102-2727*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Recognize that unidimensional models of severe psychiatric disorders are inadequate and do not account for the current scientific understanding of these disorders; 2.) Recognize that the biosocial model of severe psychiatric disorders better accounts for the current scientific understanding of these disorders; and 3.) Recognize that the biosocial model for severe psychiatric disorders lead to much more effective models of treatment and rehabilitation than its historic antecedents.

SUMMARY:

The biosocial theory - major psychiatric disorders, such as schizophrenia, are the result, both at onset and throughout their course, of the continual interaction of specific brain abnormalities and specific social factors or processes - has guided my research and my work since the late 1970's. That work has attempted to translate this theory into testable and effective treatments. This has left this body of work squarely in the middle of the two major camps in American psychiatry; the biological and psychoanalytic. The results disconfirm unidimensional approaches to treatment, whether biological/pharmacological or interpersonal/social. The lecture will use results from family psychoeducation, family-aided assertive community treatment and a model for treating prodromal psychosis to propose an alternative biosocial treatment to the historic tendency to ascribe cause to

simple models of one dimension. That alternative has gained increasing credence as limitations to psychopharmacological models have become apparent and as biosocial treatment models become increasingly effective.

REFERENCES:

1. McFarlane, W.R., L. Dixon, et. al. (2003). Family Psychoeducation and Schizophrenia: A Review of the Literature. Journal of Marital & Family Therapy 29(2):223–245.
2. McFarlane, W.R., R. A. Dushay, et. al. (1996). A Comparison of Two Levels of Family-Aided Assertive Community Treatment. Psychiatric Services 47(7):744–750.

Lecture 8 **Friday, October 12 1:30 p.m.-3:00 p.m.**

MY LAST TALK ABOUT INSURANCE PARITY: THE ROLE OF RESEARCH

Health Services Research Track

Howard H. Goldman, M.D., Ph.D., *Professor of Psychiatry, Unviversity of Maryland; Liaison, APA/IPS Scientific Program Committee; and Editor, APA Psychiatric Services Journal, 10600 Trotters Trail, Potomac, MD 20854-4241*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to describe how research has affected insurance policy for behavioral health services.

SUMMARY:

This presentation will review the policy of insurance parity for treating behavioral health conditions. The emphasis of the lecture is on the role of research on changes in policy. Originally parity was opposed because of concerns about the effectiveness of treatment for mental disorders and because of empirical evidence about the cost of behavioral health care and the distribution of those costs after changes in benefit design. The problem of effectiveness has been diminished by a growing body of research. It took further research to clarify the cost problem. Recent experiences with insurance parity coupled to management of care, such as the recent experience with the federal employees program, suggest that a policy of fairness can also provide better insurance protection without an increase in total costs.

REFERENCES:

1. Azrin ST, Huskamp H, Azzone V, Goldman HH, et. al. Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program, Pediatrics 119 (2): e452–e459, 2007.
2. Frank RG, Goldman HH, McGuire TG. Will Parity in Coverage Result in Better Mental Health Care? New England Journal of Medicine 345(23):1701–1704, December 6, 2001.
3. Goldman HH, et. al. Behavioral Health Insurance Parity for Federal Employees. New England Journal of Medicine 354(13, March 30): 1378–1386, 2006.

Lecture 9 **Friday, October 12 3:30 p.m.-5:00 p.m.**

CO-OCCURRING DISORDERS AND DISPARITIES

OMNA on Tour in the Gulf Coast Track

Rochelle Head-Dunham, M.D., *Medical Director, Louisiana Office for Addictive Disorders, 7313 Downman Road, New Orleans, LA 70126*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) List the complexities of co-occurring populations; 2.) Discuss the assessment and treatment interventions to better meet the needs of the Co-Occurring Disorders (COD) populations in mental health, addictive disorders, and primary care settings; and 3.) Define the disparities in providing effective treatment services to persons with COD and possible alternative.

SUMMARY:

Researchers and practitioners in the fields of Addictive Disorders and Mental Health have over the past few decades observed an emerging category of illness reflective of the co-occurrence of both categories of illness (Rounsaville et al. 1982b; Pepper et al. 1981, Woody and Blain 1979). Modifications to treatment approaches and practices to enhance treatment effectiveness and to improve treatment outcomes are acknowledged necessities to the provision of best practice standards of care for this population. New models of care are slowly emerging to enhance specialized services to better meet the complexity of needs. In an effort to expand the thinking in the field of addiction, the American Society of Addiction Medicine (ASAM) has provided updates to patient placement criteria to include a section on Co-Occurring Disorders (COD) (ASAM 2001). The intent of the expanded criteria is to aide in treatment placement decisions and in providing guidelines for establishing programs which provide COD services. Slower evidence of change in perceptions regarding those with COD in the public sector and within health care delivery systems requires aggressive campaigns aimed at educating and reducing stigma. Use

of tools such as the Screening, Brief Intervention, and Referral for Treatment (SBIRT) model, provides primary care providers with a valid and reliable tool that can seamlessly integrate into the standard medical procedure. Targeted groups captured by the instrument are those high-risk populations which may otherwise go undetected and later progress to meet full spectrum criteria for clinical disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). Disparities in the care of COD popluations are reflected in the variable practice patterns from referral to treatment within the addictive disorders and mental health field (Center for Substance Abuse Treatment [CSAT], 2005. Additionally, perceived barriers to providing effective treatments to persons with COD include appropriate personnel such as psychiatrists/physicians, staff who can in the addiction field, provide mental health services and vice versa, licensing and regulatory standards, billing and reimbursement issues, education/training and clinical supervision (McGover, P. et al, 2006). Expanded knowledge and experience in behavioral and psychosocial treatments for conditions most commonly seen in this population are suggested possible methods of offsetting workforce and training disparities.

REFERENCES:

1. Substance Abuse Treatment for Persons With Co-Occurring Disorders. (TIP 42) Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
2. Hunter SB, Watkins KE, Wenzel S, Gilmore J, Sheeh J, Griffin B. Training Substance Abuse Staff to Care for Co-Occurring Disorders. Journal of Substance Abuse Treatment, 2005; 28(3):239–245.

Lecture 10 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

THE ROAD LESS TRAVELED: EASTERN SPIRITUAL CONCEPTS APPLIED TO PSYCHIATRIC EDUCATION

APA's George Tarjan Award

Nalini V. Juthani, M.D., *Professor of Psychiatry, Albert Einstein College of Medicine, 17 Pheasant Run, Scarsdale, NY 10583*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Educate participants about the inner complexities of teaching and learning; 2.) Recognize the connection between education, community, and spirituality; and 3.) Define how the intellectual, emotional, and spiritual approaches to learning enhance the integration of IMGs in American psychiatry.

SUMMARY:

The George Tarjan Award was established in 1992 to recognize an individual who has made significant contribution to enhance the integration of IMG's into American psychiatry. Dr. Nalini Juthani is the 2007 George Tarjan Award recipient. This lecture will take the participants on an IMG educator's journey, toward connecting with her vocation and her IMG trainees. These connections are made not in the method, but in the heart where intellect, emotion and the spirit converge. To educate is to bring out the best in a student, through a ''Guru Chela'' (Teacher-Student) relationship, as stated in the Eastern Spiritual wisdom. Education is therefore, a spiritual journey. For an educator it is an inner calling and a relational process. IMGs who have entered a world of non-familiarity and who have been engulfed by the flames of solitary existence are like fish out of water. However, their yearning for connectedness and nurturance from a community that supports teaching and learning is vividly apparent. This IMG educator took the road less traveled to educate, nurture and enhance the integration of IMGs into American psychiatry through a spiritual journey.

REFERENCES:

1. The courage to teach: Parker J. Palmer, Jossey-Bass Publishers, San Francisco, CA 1998.
2. Handbook of Religion and Mental Health, Harold G. Koenig, Academic Press, San Diego, CA 1998.

Lecture 11 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

MEDICATION AND MEDICATION STRATEGIES FOR FIRST EPISODE SCHIZOPHRENIA

Nina R. Schooler, Ph.D., *Professor of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Recognize similarities and differences in pharmacologic treatment requirements and response between first and later episode schizophrenia; 2.) Describe the findings of comparative trials of both first and second generation antipsychotic medications; and 3.) Explain individual and familial issues that are relevant for engagement of patients in long-term treatment.

SUMMARY:

The first episode treatment of schizophrenia presents a unique clinical opportunity. The experience that a patient has during this time will color subsequent views of both

treatment and the treatment system. Patients generally respond well to medication and at a lower dose than is often needed in later illness episodes. At the same time, there are unique difficulties. There is no history of prior treatment response to guide medication choice. Patients and their families are often frightened and perplexed both by the experience of the illness and by the clinical environment. Patients, families and often clinicians are reluctant to accept the seemlingly harsh diagnosis of schizophrenia and the need for long-term (greater than a few weeks) treatment may often be rejected. This lecture will review these issues and will provide a review of comparative data from clinical trials in first episode schizophrenia, examining both short- and long-term outcomes. The lecture will conclude with a discussion of strategies for engaging patients, managing expectations, and developing long-term treatment strategies.

REFERENCES:

1. Schooler NR. The efficacy and safety of conventional and atypical antipsychotics in first-episode schizophrenia: A review of the literature. Clinical Schizophrenia and Related Psychoses: 2007; 1, 63–78.
2. Robinson DG, Woerner MG, Delman HM, Kane JM. Pharmacological treatments for first episode schizophrenia. Schizophrenia Bulletin, 2006.

Lecture 12 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

RISK FACTORS ARE NOT PREDICTIVE FACTORS DUE TO PROTECTIVE FACTORS

OMNA on Tour in the Gulf Coast Track

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc.; and Professor of Psychiatry and Public Health, University of Illinois at Chicago School of Medicine, 8704 South Constance Avenue, Chicago, IL 60617-2746*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Recognize the Adverse Childhood Experiences that have the potential to generate adverse physical health and mental health outcomes; 2.) Identify four protective interventions that prevent risk factors from being predictive of bad outcomes; and 3.) List seven community field principles that promote health behavior change.

SUMMARY:

Contrary to expections of many psychiatric practitioners, exposure to a risk factor, e.g., a traumatic stressor, does not automatically put a person on a path to develop a psychiatric disorder, e.g. PTSD. Scientific documentation will be provided that protective factors have the capacity to prevent risk factors from becoming predictive of "bad" mental health outcomes. Further, protective factors can decrease the risk individuals who are exposed to adverse childhood experiences from having serious psychopathology in later life. A theoretically-sound, evidence-based, common sense model is offered as a "directionally correct" way to ensure that at-risk populations obtain protective factors to prevent potential risk factors from generating poor health and mental health outcomes.

REFERENCES:

1. Bell, CC. Exposure to a traumatic event does not automatically put a person on a path to develop PTSD: The importance of protective factors to promote resiliency. http://www.giftfromwithin.org/html/promote.html.
2. U.S. Department of Health and Human Services (2001) Youth Violence: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services. http://www.surgeongeneral.gov.

Lecture 13 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

THE CONTINUUM BETWEEN PSYCHOSES AND ORDINARY MIND, WITH IMPLICATIONS FOR TREATMENT

Michael D. Garrett, M.D., *Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center; and Clinical Associate Professor of Psychiatry and Faculty, Psychoanalytic Institute at New York University Medical Center, 243 West 98th Street, Apt. 7-B, New York, NY 10025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) List at least two examples of evidence for there being a continuum between psychosis and ordinary mind; 2.) Define Melanie Klein's concept of the 'paranoid position' and illustrate this idea with an example from daily life and from clinical experience with psychotic patients; and 3.) Explain how an awareness of the continuum between psychosis and ordinary mind may be useful in forming a therapeutic alliance with a psychotic patient.

SUMMARY:

Many clinicians find it difficult to relate the myriad strange experiences of psychotic to themselves. Unlike mental states such as dreams, feelings of anxiety, or

slips of the tongue, which are familiar to all, most people find psychotic symptoms bizarre, baffling, seemingly beyond empathic understanding. Recently evidence would argue that psychotic experiences lie along a continuum with ordinary mind and so may not be as incomprehensible as once thought. Three types of evidence in support of this view will be examined: 1.) Phenomenological studies comparing psychotic individuals and community samples; 2.) Psychoanalytic concepts of psychosis which connect psychosis and ordinary mind, with an emphasis on the ideas of Melanie Klein; and 3.) Data from cognitive psychological which links cognitive biases observed in psychosis with cognitive processes apparent in everyday life. Awareness of this continuum provides a new basis for the clinician's therapeutic alliance with psychotic patients.

REFERENCES:

1. Garret, M. Stone, D. and Turkington, D. Normalizing Psychotic Symptoms, Psychology and Psychotherapy: Theory, Research, and Practice, Vol 79, Part 4, 2006.
2. Kingdon, D.G., and Turkington, D. Cognitive-Behavioral Therapy of Schizophrenia. New York: Guilford, 2005.

Lecture 14 **Saturday, October 13 1:30 p.m.-3:00 p.m.**

PHARMACOLOGIC TREATMENT OF SCHIZOPHRENIA: HOW FAR HAVE WE GONE?

John M. Kane, M.D., *Chair, Department of Psychiatry, The Zucker Hillside Hospital; and Professor of Psychiatry, Neurology, and Neuroscience, Albert Einstein College of Medicine*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Update attendees on the latest findings from clinical trials; 2.) Review outcome measures relevant to pharmacologic treatment in clinical practice; and 3.) Discuss benefit-to-risk considerations in establishing treatment plans.

SUMMARY:

Pharmacologic treatment is a mainstay in the short- and long-term management of schizophrenia. It is important for clinicians to be familiar with the literature on risks and benefits of medication, as well as the relative merits of different drugs or drug classes. In addition, in routine practice it is important for clinicians to have clinically meaningful and easily applied metrics for evaluating drug effects, both therapeutic and adverse. Having clearly articulated (and documented) clinical targets and goals is important in informing clinical decision-making at every stage of treatment. It is particularly challenging for clinicians to decide when to change dosage, change medication or add adjunctive medications. The role of neurologic and metabolic side effects, as well as sedation, are important considerations in establishing treatment plans and monitoring outcome.

REFERENCES:

1. Andreasen N, Carpenter W, Kane J, Lasser R, Marder S, Weinberger D. (2004) Remission in Schizophrenia: Proposed Criteria and Rationale for Consensus. Am J Psychiatry 162(3):441–9, 2005.
2. Leucht S, Kane JM, Kissling W, Jamann J, Etschel E, Engel R. What does the PANSS mean? Schizophrenia Research, 79(2–3):231–8, 2005.

Lecture 15 **Saturday, October 13 1:30 p.m.-3:00 p.m.**

PSYCHODYNAMICS: A RELEVANT THREAD IN A WORLD OF MULTIPLE THERAPIES

APA's Alexandra Symonds Award

Silvia W. Olarte, M.D., *Clinical Professor of Psychiatry, New York Medical College, 25 East 83rd Street, Apt. 9-D, New York, NY 10028-0446*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize, in the context of a psychodynamic approach, similarities and differences of the major therapeutic approaches in use today and their clinical use.

SUMMARY:

Residents and early career psychiatrists are being asked to be proficient in at least four different types of therapies, supportive, interpersonal, cognitive and psychodynamic. Within these four major groups, therapies subtypes continue to develop confusing the field even further. These various therapeutic approaches are presented as if they would have little in common. Still all of them are based on meeting with the patient on a consistent basis, using language as the main therapeutic tool and developing a therapeutic relationship within specific boundaries that fosters trust and have as their goal to decrease the presence of symptoms and to affect character formation. This lecture will clarify the concept of psychodynamics and will build on current therapies' similarities and highlight their differences using pertinent clinical vignettes.

REFERENCES:

1. Plakum EM, ''Finding psychodynamic psychiatry lost generation''. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry: 33:1; 135–150, Spring 2006.
2. Mitchell SA, Black MJ. Freud and beyond: A history of modern psychoanalytic thought. Basic Books, 1995.

Lecture 16 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

WHAT WE HAVE LEARNED FROM ASIAN TRAUMA: THIRTY YEARS EXPERIENCE WITH REFUGEES

APA's Kun-Po Soo Award

J. David Kinzie, M.D., *Professor of Psychiatry, Oregon Health and Science University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239-3011*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to: 1.) Recognize the epidemiological evidence of massive trauma among Asians; 2.) Identify the multiple clinical symptoms and social effect of the treatment; and 3.) Treat traumatized Asian refugees, using therapeutic approaches.

SUMMARY:

Asia has a long and sad history of warfare. In this century World War II moved directly into the Indochina War which resulted in massive death, the Pol Pot concentration camps, and refugees coming from Vietnam, Cambodia and Laos. Clinical and epidemiological data indicate that 40–50% of these refugees had PTSD and depression. The symptoms and disabilities have long-term consequences including social impairment, difficulty raising children, and a high rate of diabetes and hypertension. In addition, even with treatment patients are vulnerable to reactivation by further traumatic experiences. Treatment needs to be comprehensive with ethnic mental health workers and cross-cultural effective and competent psychiatrists. The major importance is the quality of the doctor/patient relationship.

REFERENCES:

1. Kinzie JD, Boehnlein JK, Leung PK, et al. The prevalence of Post-Traumatic Stress Disorder and its clinical significance among southeast-asian refugees. The American Jouranl of Psychiatry. 1990; 147: 913–917.
2. Kinzie JD. Psychotherapy for massively traumatized refugees: The therapist variable. American Journal of Psychotherapy. 2001; 55:475–490.

Lecture 17 **Saturday, October 13 3:30 p.m.-5:00 p.m.**

CULINARY ASPECTS OF NEW ORLEANS

Tom Fitzmorris, *Publisher, The New Orleans Daily Menu, and Leading Restaurant Critic, P.O. Box 1647, Abita Springs, LA 70420*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to compare and evaluate various restaurants in New Orleans, and recognize how Hurricane Katrina affected the chefs and restaurant workers throughout the city during this disaster.

SUMMARY:

In the days before August 29, 2005, as the approach of Katrina triggered the annoying annual evacuation odyssey, New Orleanians had no idea their dreamy, professionally lethargic, down-but-not-out lifestyle was about to be taken from them. For weeks, virtually all 460,000 residents were stuck on someone's sofa, in a hotel or on a cot in an arena somewhere. The shattered pieces of a city, and a culture, were strewn across the country. Susan Spicer, is a chef and owner of several New Orleans restaurants. Even though her Lakeview home flooded, even though business at her most famous restaurant, Bayona, in the French Quarter, is down almost 40%, she's here for the long haul. ''It feels pretty good to be here, but it's a little scary,'' she says. Tourists, who make up a large portion of her clientele, are noticeably absent these days. And running a restaurant is more expensive, Spicer and others say. Wages are up because of a severe worker shortage. Electric bills are at least 20% higher. This lecture will not only recommend and discuss the great restaurants in New Orleans, it will also focus on how Hurricane Katrina impacted the entire restaurant industry in this City.

REFERENCES:

1. Fitzmorris T, New Orleans food scene rebounded quickly after Hurricane Katrina; New Orleans City Business, June 12, 2006.
2. Severson K, Can New Orleans Save the Soul of its Food?; Dining and Wine, January 11, 2006.

Medical Update 1 — Thursday, October 11, 3:30 p.m.-5:00 p.m.

SEXUAL DISORDERS AND TREATMENTS

Wayne Hellstrom, M.D., *Department of Urology, Tulane University Hospital and Clinic, 1430 Tulane Avenue, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this medical update, the participant should be able to recognize new treatment strategies for patients who have a variety of sexual disorders.

SUMMARY:

Although the majority of sexual dysfunction probably has a physical basis, whether mainly due to physical or psychological causes, having a sexual dysfuntion can result in distress. For example, the individual with a sexual disorder may suffer related anxiety and sexual frustration which in turn leads to insomnia, and that insomnia may be the presenting complaint to the general practioner. The individual's close relationships may suffer and tension may build up in the family as a whole. According to the *DSM-IV* there are a dozen or so sexual disorders. All have to cause marked distress or interpersonal difficulty to rate as disorders. This medical update will address most of these 12 disorders and provide treatment options.

REFERENCES:

1. Spector KR, Boyle M: The Prevalence and Preceived Aetiology of Male Sexual Problems in a Non-Clinical Sample. Br J Med Psychol 59:351–358, 1996.
2. Kilpatrick AC: Some Correlates of Women's Childhood Sexual Experiences: A Retrospective Study. J Sex Res 22:221–242, 2002.

Medical Update 2 — Sunday, October 14, 8:00 a.m.-9:30 a.m.

SEQUELAE OF TRAUMATIC BRAIN INJURY

Jeffrey S. Nicholl, M.D., *Department of Psychiatry and Neurology, Tulane University School of Medicine, 1440 Canal Street, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this medical update, the participant should be able to: 1.) Define the pathophysiology of traumatic brain injury (TBI); 2.) Identify the techniques used in evaluation of patients with TBI; 3.) Recognize the various behavioral syndromes related to TBI and how they differ from similar syndromes in patients without TBI; and 4.) List the behavioral and pharmacologic treatments for these syndromes.

SUMMARY:

The numbers of patients with traumatic brain injury (TBI) is growing rapidly. Behavioral consequences of TBI are extremely common. This presentation will include a brief overview of the pathophysiology of TBI and the various testing modalities imaging, clinical neurophysiology, and psychometric testing, used in these patients. A detailed presentation of the evaulation and treatment of patients with these disorders will also be presented. The range of psychopathology runs the full gamut of psychiatric practice. Mood disorders, particularly depression, are a major source of morbidity in this patient population. A wide variety of personality disorders including apathetic, labile, disinhibited, aggressive and paranoid are very troublesome. Post-Traumatic Stress Disorder, cognitive deficits, pain, substance abuse, psychosis, and chronic pain are other issues which will be addressed. Behavioral and psychopharmacological treatment of these disorders will also be presented.

REFERENCES:

1. Warden DL, Gordon B, McAllister TW et.al. Guidelines for the Pharmacologic Treatment of Neurobehavioral Sequelae of Traumatic Brain Injury. Journal of Neurotrauma; 23(10), 1468–1501, 2006.
2. Silver JM, McAllister TW, Yudofsky SC. Textbook of Traumatic Brain Injury. APA Publications, Arlington, 2005.

Medical Update 3 — Sunday, October 14, 10:00 a.m.-11:30 a.m.

THE METABOLIC SYNDROME: A REVIEW FOR MENTAL HEALTH PROFESSIONALS

Nathaniel S. Winstead, M.D., M.S.P.H., *Fellow, Division of Gastroenterology and Hepatology, University of Alabama at Birmingham, 3349 Brookwood Road, Birmingham, AL 35223-2020*

EDUCATIONAL OBJECTIVES:

At the conclusion of this medical update, the participant should be able to: 1.) Discuss the definition(s) of the metabolic syndrome; 2.) Explain the prevalence and risk factors for the metabolic syndrome; 3.) Recognize the clinical implications of metabolic syndrome including diabetes, heart and vascular disease, colon cancer, and liver disease; 4.) Review special considerations about the metabolic syndrome in the psychiatric population; 5.) Understand treatment of the metabolic syndrome and its components; and 6.) Discuss controversies about the metabolic syndrome and whether it is really a "syndrome".

POSTER SESSION 1

Posters 1–29
Thursday, October 11

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

ADDRESSING SEVERE MENTAL ILLNESS

Poster 1 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

CLINICAL REMISSION IN A MULTI-ETHNIC URBAN POPULATION OF OLDER ADULTS WITH SCHIZOPHRENIA

Azziza O. Bankole, M.D., *Psychiatry Resident, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, P.O. Box 1203, Brooklyn, NY 11203*; Carl I. Cohen, M.D.; Ipsit V. Vahia, M.D.; Shilpa P. Diwan, M.D.; Pia N. Reyes, M.D.; Mamta Sapra, M.D.

SUMMARY:

Objective: Clinical remission has been documented in patients with schizophrenia. This study aims to determine the prevalence of clinical remission in older adults with schizophrenia.

Methods: The Schizophrenia Group consisted of 198 persons aged 55+ living in the community who developed schizophrenia before age 45. We excluded persons with substantial cognitive impairment. We established criteria for clinical remission based on a comprehensive literature review. The criteria we chose as a framework for remission chart the three dimensions of psychopathology in schizophrenia i.e., reality distortion, disorganisation, and negative symptoms. The Positive and Negative Symptom Scale (PANSS) and history of hospitalization were the criteria used. Scores of 3 or below on 8 domains of the PANSS (P1, P2, P3, N1, N4, N6, G5, & G9) and no hospitalizations within the previous year. Summed scores based on all these criteria determined remission rates. No demographic variables correlated with remission.

Results: 48.5% of our sample met the clinical criteria for remission. Using bivariate analysis, we found that remission correlated with a fewer network of contacts, greater proportion of intimates, higher IADL, QLI, DRS scores and lower CESD and trauma scores. These individuals also compared themselves favourably with others without mental illness. In logistic regression, 4 variables—fewer total network contacts, greater proportion of intimates, fewer lifetime traumatic events, and higher DRS scores—retained significance. The type of residence, use of mental health services, and medication were not found to correlate with remission.

Conclusions: Remission rates based on our data were consistent with rates reported in the literature. Our findings suggest that clinical remission is an attainable goal. Factors that influence clinical remission merit closer study, and development of treatment models based on these studies may augment outcomes in the older population with schizophrenia.

REFERENCES:

1. Andreasen NC, Carpenter WT Jr, Kane JM, Lasser RA, Marder SR, Weinberger DR: Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry. 2005 Mar;2(3):441–9.
2. van Os J, Drukker M, a Campo J, Meijer J, Bak M, Delespaul P: Validation of remission criteria for schizophrenia. Am J Psychiatry. 2006 Nov; 3(11): 2000–2.

Poster 2 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

CORRELATIONS BETWEEN MISMATCH NEGATIVELY (MMN) AND INSIGHT IN SCHIZOPHRENIA

Albert M. Boxus, Psy.D., *Psychiatrist, ASS Audoise Sociale et Medicale, Place du 22 Septembre, Limoux, France 11300*

SUMMARY:

Background: Mismatch Negativity (MMN) is an event-related potential which reflects echoic memory. It disappears in deep sleep, but is present in rapid-eye movement sleep. Thus it affects archaic mnemic processes which can be the reflection of insight capacities. MMN amplitude is usually reduced in schizophrenia. MMN amplitude is correlated with the correct operation gabaergic. The hypofrontality observed in schizophrenia is in bond with the reduction in insight highlighted in these pathologies. MMN could be thus an evaluation of insight capacities. The aim of this study was to investigate the correlation between MMN amplitude and cognitive insight in schizophrenia.

Methods: 14 individuals (10 males and 4 females; mean age= 40.9 years [SD= 13.7]) with schizophrenic diseases (*DSM-IV*) were evaluated. The studied parameters were: MMN amplitude and the BECK Cognitive Insight Scale (BCIS). We classed patients in "bad insight" when agreement in BCIS was slightly or not at all.

Results: Mean MMN amplitude was −2.0 μVolt (SD= 1.4), distributed from −5.5 to −0.1μVolt. We observed a correlation between MMN amplitude and a bad insight evaluated with the BCIS ($p<0.05$).

Conclusion: These results have to be confirmed in a larger study, but suggest that insight of schizophrenic patients may be, at least in part, mediated through cognitive change indexed by MMN and could be evaluated with this objective test. MMN evaluation could therefore help psychiatrists for prognostic and therapeutic decisions.

REFERENCES:

1. Mintz, Dohsno, Rommey: Insight in schizophrenia: a meta-analysis Schizophrenia Research 2003.
2. Aaron T. Beck, Edward Baruchb, Jordan M. Balterb, Robert A. Steerb, Debbie M. Warmana. A new instrument for measuring insight: the Beck Cognitive Insight Scale; Schizophrenia Research, 68 (2004) 319–329.

Poster 3 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

THE EFFECT OF SECOND GENERATION ANTIPSYCHOTIC DRUGS ON EVENT RELATED POTENTIALS (ERPS) IN SCHIZOPHRENIA: A PRELIMINARY STUDY

Albert M. Boxus, Psy.D., *Psychiatrist, ASS Audoise Sociale et Medicale, Place du 22 Septembre, Limoux France 11300*

SUMMARY:

Background: The effects of the second generation antipsychotic drugs (risperidone, olanzapine, clozapine) on cognitive dysfunction have been investigated by Event Related Potentials (ERPs) in schizophrenia. However, to the best of our knowledge, the effect of amisulpride and aripiprazole remain unknown. The aim of this study was to investigate the potential effect of all these drugs on ERPs in schizophrenia.

Methods: Fifty-five individuals (32 males and 23 females; mean age=35.9 [SD=13.8]) meeting *DSM-IV* criteria for schizophrenia, admitted for an acute relapse, were included in the study and observed within an eight month period from 2005/10 to 2006/07. They were treated with the following antipsychotics (mean daily dosage): aripiprazole (13.75 mg), rispéridone (5.06 mg), olanzapine (14.12 mg), amisulpride (1000 mg) and clozapine (150 mg). The other psychotropic drugs were prohibited except for cyamemazine (100mg/d during the first week), benzodiazepines, zolpidem and anticholinergic medications. Clinical and electrophysiological evaluations were performed before the start of treatment (T1) and after remission (T2). Psychopathology was measured by the Positive and Negative Syndrome Scale (PANSS) and Brief Psychiatric Rating Scale (BPRS).

Results: The mean follow-up was 5 months.

P300 latency (ms) P300 amplitude (?V)

P300 reaction time (ms) P300 false-alarm all treatments

n=55 T1 321.4± 28.7 9.2± 4.4 274.2± 63.2 3.8± 4.5

T2 315.8± 24.3 12.1± 8.7 263.1± 58.7 3.5± 4.5

aripiprazole

N= T1 325.1± 24.2 7.9± 2.8 260.6± 41.83.1± 2.5

T2 315.7± 28.6 11.1± 3.6 252.1± 47.0 3.1± 3.4

amisulpride

N=4 T1 304.2± 33.1 12.1± 3.0 273.8± 52.9 2.2± 2.1

T2 3.3± .2 9.8± 4.7 228.0± 38.7 10.0± 13.6

clozapine

N=1 T1 328.1 12.2 195.3 4.0

T2 307.5 22.0 204.3 4.0

olanzapine

N=17 T1 323.2± 26.9 11.2± 5.3 293.1± 83.6 5.1± 6.1

T2 314.9± 24.6 13.0± 6.6 258.3± 59.02.8± 2.5

risperdone

N=17 T1 319.7± 34.6 7.5± 3.9 272.8± 52.93.6± 4.9

T2 317.3± 23.6 12.0± 13.7 290.0± 66.02.9± 2.4

After treatment, P300 latency was not significantly improved but we observed a significant increase in P300 amplitude ($p<0.02$). P50 suppression deficit, which was present in 49 subjects at T1, was observed in only 44 patients at T2 ($p<0.003$). This improvement occurred particularly in patients receiving aripiprazole or risperidone. PANSS and BPRS decreased respectively from 100± 12 and 85± 8 at T1 to 53± 11 and 38± 6 at T2 ($p<0.01$)

Conclusion: The effect of the antipsychotic drugs studied herein are different regarding to the evaluation test used. These results suggest that clinical improvement in response to treatment may be, at least in a part, mediated through cognitive change indexed by P300 and P50 suppression in schizophrenia.

REFERENCES:

1. Johannsesen JK: contributions of subtype and spectral frequency analyses to the study of P50 ERP amplitude and suppression in schizophrenia. Shizoph. Res. 2005; 78:269–284.
2. Van Der Stelt O: impaired P3 generation reflects high level and progressive neurocognitive dysfunction in schizophrenia. Arch Gen Psychiatry 2004; 61:237–24.

Poster 4 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

NEUROPSYCHOLOGICAL ASSISTANCE FOR PATIENTS WITH SLEEP DISTURBANCES AT SANTA CASA DE SAO PAULO

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Paula Ana Braga, M.Psy.

SUMMARY:

Objective: Chronic insomnia can decrease quality of life. This is motivated by attention and memory decrease. Studying these neuropsychological aspects we can better assist the insomniac patients. Through neuropsychological tests, to study the attention, memory, praxis, language e executive functions range of chronic insomniac patients.

Methods: 32 insomniac patients were studied at sleep disturbance sector of Santa Casa de São Paulo. The cognitive function was scored through ten neuropsychological tests.

Results: We noticed decrease of attention in 26 (81,25%), short-term memory in 10 (31,25%), long-term memory in 19 (59,4%), disturbance in language in 2 (6,25%), constructive praxis in 10 (31,25%) and executive function in 6 (18,25%). Only one patient (3%) was low intellectual indices.

Conclusions: For chronic insomnia, the main disturbance at neuropsychological tests was decrease of attention. Another disturbance was decrease of long-term memory. The continued evaluation of this dysfunctions can be an auxiliary exam to increase the insomnia treatment.

REFERENCES:

1. Nitrini R. – Conceitos anatômicos Básicos em Neuropsicologia. In: Nitrini, R.; Caramelli, P.& Mansur, L. L. (Orgs.), Neuropsicologia: Das Bases Anatômicas à Reabilitação. HCFMUSP. São Paulo, 1996.
2. Lezak M. – Neuropsychological Assessment. Oxford University Press. New York, 1995.

Poster 5 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

APPROACH TO THE SLEEP DISTURBANCES AT SANTA CASA DE SAO PAULO

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Paula Ana Braga, M.Psy.; Adriana Fregonese, M.Psy.

SUMMARY:

Objective: To analyze patients assisted at section of sleep disturbances of Santa Casa de São Paulo and with reference to the epidemiologic foreign and national studies centers data.

Methods: We reviewed the history of 57 patients over 17 years old assisted at sleep disturbance sector of Santa Casa and analyzed gender, age, marital status and the need for complementary results. We excluded patients that were waiting complementary exams. Diagnosis were classified according to the International Classification of Sleep Disorders (lCSD) 2005 and Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition,. Text Revision (*DSM-IV-R*).

Results: The age range is 45.3 years old (range 45.8 years old for male and 44.9 years old for female). The youngest patient is 17 years old and the oldest one is 78 years old. 22 are male (38,6%) and 35 are female (61,4%). 35 are married, 14 are only, 5 are divorced, and 3 are widowed. For 52 (92%) patients polysomnography were requested. For 21 patients (37%) neuropsychological tests were requested. The main initial symptoms were: 50,8% insomnia, 19,3% excessive sleepiness, 12,3% snore, 3,5% apnea and 14,1% parassomnias (sleep walking, nightmares, confusional wake up ...). For 29 patients (51%) there were more than three (03) sleep disturbances. Major depression disease was noticed at 21 patients (37%) and global anxiety disturbance was noticed at 13 patients (23%). 9 patients (%) had both symptoms.

Conclusions: Females between ages 40 to 60 years old and married man were predominance. Insomnia was the most frequent symptom after excessive sleepiness. In 51% of the patients assisted was noticed more than one sleep disturbance. We noticed that there are so few epidemiologic studies in Brazil, as well as others countries. This fact became so difficult to us to compare and connect the results of this presentation with the epidemiologic data. We believe that is so important the development of educational programs about sleep disturbances approaching them to health or general public.

REFERENCES:

1. Lezak, M. – Neuropsychological Assessment. Oxford University Press. New York, 1995.
2. Mendes, M. F.; Tilbery, C. P.; Balisimelli, S. F.; Moreira, M. A. & Barao Cruz, A. M. – Depressão na Esclerose Múltipla Forma Remitente-Recorrente. Arquivos de Neuropsiquiatria, 61 (3-A): 591–595, 2003.

Poster 6 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

A DESCRIPTIVE STUDY OF THE PRODROMAL PERIOD IN NEWLY HOSPITALIZED PATIENTS WITH FIRST-EPISODE NON-AFFECTIVE PSYCHOSIS

Michael T. Compton, M.D., M.P.H., *Assistant Professor, Psychiatry and Behavioral Sciences, Emory University, 48 Jesse Hill Jr. Drive S.E., Room 333, Atlanta, GA 30303*

SUMMARY:

The prodrome of non-affective psychosis is of increasing research interest because the duration of untreated illness is a predictor of outcomes in the early course of schizophrenia, and initiating care during this period may delay or prevent the onset of psychosis. This study described the retrospectively-assessed prodromal period of 75 hospitalized, predominantly African American, first-episode patients. The median prodrome duration was 26.2 weeks (mean: 95.8+/–125.8, range: 0–476.7), and did not differ by gender or family history of psychosis. The median duration from the onset of prodromal symptoms to first professional help contact (which typically occurred after psychosis had developed) was 49.4 weeks (mean: 125.0+/–146.6, range: 0–743.7). The most prevalent of 15 assessed prodromal symptoms were: social withdrawal (66.2%), deterioration in role function (63.4%), suspiciousness (55.6%), trouble with thinking (50.7%), and sleep disturbance (48.3%). Only seven participants had sought professional help during the prodrome (three saw a family doctor, three visited a mental health professional, and one had contact with a police officer). In this sample, duration and phenomenology of the prodrome was highly variable and few individuals contacted professional help during their prodromal period. Such descriptions may inform future efforts aimed at identifying and offering preemptive psychiatric services.

REFERENCES:

1. Yung AR, McGorry PD. The initial prodrome in psychosis: descriptive and qualitative aspects. Austr N Z J Psychiatry 1996;30:587–599.
2. Tully EM, McGlashan TH. The Prodrome. In Lieberman JA, Stroup TS, Perkins DO. Textbook of Schizophrenia. Washington, DC: American Psychiatric Publishing, Inc., 2006; pp. 341–352.

Poster 7 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

MENTAL HEALTH PROVIDER INVOLVEMENT IN DIABETES MANAGEMENT

Brian Cooke, M.D., *Resident, Department of Psychiatry, University of Maryland, 701 W. Pratt Street, Baltimore, MD 21201*; Ann L. Hackman, M.D.; Richard Goldberg, Ph.D.; Lisa Dixon, M.D., M.P.H.

SUMMARY:

Background: Diabetes affects –25% of people with schizophrenia, a rate four to five times higher than the general population. Both mental health and primary care play a role in managing diabetes among persons with severe mental illness (SMI).

Objective: We examined the involvement of community- based mental health providers (MHP's) in patients' diabetes care and tested whether clinical or demographic variables were correlated with MHP involvement.

Methods: Sample included 100 persons with schizophrenia and 101 with major mood disorders who were also diagnosed with Type 2 Diabetes. Participants were asked if in the past six months their MHP asked about diabetes behaviors, diabetes medications, asked to speak with their diabetes doctor, or provided diabetes education.

Results: About 49% of participants reported that their MHP's asked about diabetes health behaviors. Close to 40% reported being asked about diabetes medication. Only 18% reported that their MHP's asked to speak with their diabetes doctor. Age, gender, race, and education were not significantly associated with patients' reports of mental health involvement in diabetes care. Participants with schizophrenia were more likely to be asked about diabetes medication than patients with major affective disorders (OR 3.29 (95%C.I: 1.37–7.91), $p < 0.05$). People who had more psychiatric symptoms (SF-12 score) were more likely to report any diabetes related intervention (OR 0.94, $p < .001$).

Conclusions: 1.) Recent research establishing the link between diabetes and psychiatric treatment underscores the importance of monitoring by MHP's of diabetes care; and 2.) This study suggests that among patients with established diabetes, MHP's are beginning to attend to medical issues and should continue to coordinate efforts with primary care physicians.

REFERENCES:

1. Morbidity and Mortality in People With Serious Mental Illness. Technical report 66. Alexandria, Va. National Association of State Mental Health Program Directors, Medical Directors Council, 2006. Available at www.nasmhpd.org.

2. Dixon LB, Kreyenbuhl JA, Dickerson FB, et.al.: A comparison of type 2 diabetes outcomes among persons with and without severe mental illness. Psychiatric Services 55: 892–900, 2004.

Poster 8 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

THE THERAPEUTIC BENEFIT OF A SINGLE EPISODE OF AEROBIC EXERCISE ON MOOD IN PATIENTS WITH SCHIZOPHRENIA

Dale A. D'Mello, M.D., *Associate Professor, Department of Psychiatry, Michigan State University, St. Lawrence-Sparrow Hospital, 1210 W. Saginaw, Lansing, MI 48917*; Lynette Craft, Ph.D.

SUMMARY:

Patients with schizophrenia are typically sedentary and disinclined to exercise. Literature regarding the effect of physical exercise in this condition is relatively sparse and inconclusive.

Objective: The purpose of the present study was to examine the immediate effect of a single episode of moderate grade aerobic exercise on mood and vitality in patients with schizophrenia.

Methods: Twenty hospitalized patients with the diagnosis of schizophrenia completed a 30 minute aerobic activity riding an exercise bike to targeted exercise training pulse rates. The patients completed the Profile of Mood States (POMS) before and immediately after the exercise. The mean baseline POMS sub-scores were compared statistically to the mean post-exercise subscores. The statistical significance of the difference between the mean sub-scores was assessed using a 2-tailed t-test.

Results: The mean POMS Tension-Anxiety score dropped from 23 (SD=20) to 9 (SD=8) t=3.53, df=15, p=0.003, the Depression-Dejection score decreased from (SD=14) to 12 (SD=14), t=2.58, df=15, p=0.021. The Anger-Hostility sub-score declined from 10 (SD=10) to 7 (SD=10), t=1.37, df=15, p=0.191.

Conclusions: Moderate grade aerobic physical exercise produced measurable and statistically significant changes in anxiety, depression, and anger. Physical exercise may prove to be a practical and inexpensive augmentation strategy in the management of patients with schizophrenia.

REFERENCES:

1. Centorrino F, Wurtman JJ, Duca KA, Fellman VH, Fogarty KV, Berry JM, Guay DM, Romeling M, Kidwell J, Cincotta SL, Baldessarini RJ: Weight loss in overweight patients maintained on atypical antipsychotic agents. Int J Obes (Lond). 2006 Jun;30(6):1011–6.
2. Beebe LH, Tian L, Morris N, Goodwin A, Allen SS, Kuldau J: Effects of exercise on mental and physical health parameters of persons with schizophrenia. Issues Ment Health Nurs. 2005 Jul;26(6):661–76.

Poster 9 **WITHDRAWN**

Poster 10 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

FINDINGS FROM A NATIONAL METABOLIC SCREENING PROGRAM FOR PSYCHIATRIC OUTPATIENTS

Supported by Pfizer Inc.

Suzanne Girdano, Ph.D., *Director/Team Leader, Regional Medical Research Specialist, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Benjamin G. Druss, M.D., Christoph U. Correll, M.D.; Antony D. Loebel, M.D.; Manuel Garcia, M.D.; Cynthia Siu, Ph.D.; Brian Cuffel, Ph.D.

SUMMARY:

Objective: To determine the prevalence of metabolic disturbance and other health conditions in patients taking psychotropic medications, in a variety of public mental health facilities and community behavioral health clinics [1].

Method: A 1 day, voluntary metabolic health fair funded by Pfizer beginning in 2005, which offered patients free metabolic screening and same-day feedback from a HIPAA-compliant biometrics testing third party.

Results: The first 10,111 patients at 219 sites were included in this analysis, with the majority having a self-reported schizophrenia or Bipolar Disorder diagnosis (70%). Participant characteristics were: mean age 44.5 years, 57% female, 55% Caucasian, 19% African American, and 6% Hispanic. Screening results indicated substantial elevation in metabolic risks: 51% had metabolic syndrome [2], 54% were obese (BMI =30), 81% were overweight/obese (BMI =25), 35% had elevated total cholesterol (TC =200 mg/dL), 46% had suboptimal HDL (=40 mg/dL), 28% had elevated triglycerides (TG =200 mg/dL), 12% had elevated fasting glucose (=126 mg/dL), and 32% were hypertensive (=140/90 mmHg). Up to 61% of patients with metabolic syndrome was not receiving treatment.

Conclusions: The prevalence of weight, lipid and glucose abnormalities was substantial and frequently untreated or under-treated among participants in this national mental health clinic screening program.

REFERENCES:

1. J.P. McEvoy, et.al. Prevalence of the metabolic syndrome in patients with schizophrenia: baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophr Res, 2005. 80(1): p. 19–32.
2. Third Report of the Expert Panel on Detection, Evaluation, and Treatment of the High Blood Cholesterol in Adults (Adult Treatment Panel III): Executive Summary. JAMA, 2001. 285(19): p. 2486–2497.

Poster 11 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

CLINICAL AND ECONOMIC CONSEQUENCES OF ORAL ATYPICAL ANTIPSYCHOTICS IN SCHIZOPHRENIA

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Jacqueline Peso, Ph.D., M.P.H., *Employee, Ortho-McNeil Janssen Scientific Affairs Inc., 3133 Castle Peak Avenue, Superior, CO 80027*; Natalie Edwards, M.S., Dennis M. Meletiche, Pharm.D. Luella Engelhart, M.S.; Jay Sherr, Ph.D.; Ann Thompson, M.S.

SUMMARY:

Purpose: To assess clinical and economic consequences of oral atypical antipsychotics (paliperidone ER, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole) in patients with an acute exacerbation of schizophrenia over one-year from a healthcare system perspective.

Methods: Published medical literature, unpublished clinical trial and database information, and a clinical expert panel populated a decision tree model. Inputs included rates of discontinuation, response and relapse, frequency and duration of relapse, adverse events, resource utilization and unit costs. Outcomes included percentage of patients discontinuing, days without therapy, percentage, number and duration of relapses, and direct medical costs.

Results: Over one-year, clinical outcomes did not vary considerably among products due to significant switching and discontinuation of antipsychotic medication altogether. Economic outcomes varied among products: paliperidone ER was associated with direct medical cost savings per patient per year compared to risperidone ($977), quetiapine ($1,276), olanzapine ($1,453), ziprasidone ($2,001), and aripiprazole ($2,198). Results were robust because conclusions were not affected by implementing alternate values in the model.

Conclusions: This analysis supports the notion that frequent discontinuation of medication is a problem with prescription treatments for schizophrenia. Patients with schizophrenia need access to many medication choices to help them through a lifetime of treatment.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et.al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. NEJM 2005; 353(12): 1209–23.
2. Dossenbach M, Arango-Davila C, Silva Ibarra H, et. al. Response and relapse in patients with schizophrenia treated with olanzapine, risperidone, quetiapine, or haloperidol: 12-month follow-up of the Intercontinental Schizophrenia Outpatient Health Outcomes (IC-SOHO) study. J Clin Psychiatry 2005; 66(8):1021–30.

Poster 12 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

EFFICACY OF ZIPRASIDONE IN HOSPITALIZED SCHIZOPHRENIC PATIENTS WITH SEVERE SYMPTOMS

Supported by Pfizer Inc.

Meg Frazer, M.D., *Regional Medical and Research Specialist, Neuroscience, Pfizer Inc., 235 E. 42nd Street, New York, NY 10017*; Michael H. Allen, M.D.; Antony D. Loebel, M.D.; Vicki Roy, M.S.

SUMMARY:

Background: Previous research has provided evidence for efficacy of oral ziprasidone in schizophrenic subjects with a higher severity of agitation at baseline. 1.) The current analysis was intended to assess the overall efficacy of ziprasidone in subjects with severe schizophrenic illness.

Methods: Data were pooled from 2 similarly designed 6-week, fixed-dose, placebo-controlled trials of ziprasidone in patients with schizophrenia and schizoaffective disorder. We selected subjects with baseline PANSS total scores > 100, reflecting a high baseline severity of psychopathology (2). Change in PANSS total score from baseline to end point (last visit) was evaluated by dose group (ziprasidone 40 mg/d [n = 29], 80 mg/d [n = 37], 120 mg/d [n = 23], 0 mg/d [n = 33] and placebo [n= 33]) using ANCOVA.

Results: Effect size (Cohen's d) improved with increasing dose, ranging from 0.20 (40 mg/d) to 0.60 (0 mg/d). Statistically significant improvement vs placebo was observed at 0 mg/d.

Conclusion: Within the dose range studied, ziprasidone 0 mg/d is associated with optimal treatment response in patients with schizophrenia with high baseline PANSS scores.

REFERENCES:

1. Schooler N, Mintzer J, Loebel A, et al. Relationship between agitation severity and ziprasidone treatment response in patients with schizophrenia.
2. Leucht S, Kane JM, Kissling W, et.al. What does the PANSS mean? Schizophr Res. 2005;79:231–238.

Poster 13 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

ORAL ZIPRASIDONE BIOAVAILABILITY: EFFECT OF MEAL COMPOSITION

Supported by Pfizer Inc.

Manuel E. Garcia, M.D., *Neuroscience-Psychiatry, Pfizer Inc., 1539 S.E. 8th Street, Deerfield Beach, FL 33441*; Kuan Gandelman, Ph.D.; Jeffrey Alderman, Ph.D.; Mark Versavel, M.D.; Ilise D. Lombardo, M.D. Sheldon H. Preskorn, M.D.

SUMMARY:

Food increases oral ziprasidone bioavailability, and may be necessary to achieve adequate brain D2 receptor occupancy. We explored the influence of food on ziprasidone bioavailability in 3 pharmacokinetic studies. The first study examined the effect of the FDA standard meal (60% fat) on ziprasidone (20–80 mg) absorption while the second compared the FDA meal with a lower-fat meal (30% fat) on ziprasidone (40 mg) absorption. Study 3, in patients with schizophrenia, examined the effects of calories (250–1000 kcal) and fat (15 or 50%) on steady-state (80 mg bid) serum ziprasidone concentrations. In study 1, the serum ziprasidone AUC was greater in fed than fasting states (20 mg, +48%; 40 mg, +87%; 80 mg, +101%). Increases in AUC with dose were only dose-proportional in the fed state. In study 2, AUC increased 104% and 79% (60% and 30% fat meals respectively) compared with the fasting state. In study 3, increases (~85%) in ziprasidone exposure above fasting state occurred only following 500- and 1000-kcal meals. Fat content did not significantly impact exposure. Variability in exposure was reduced in all studies by food. In summary, ziprasidone bioavailability is enhanced, and variability reduced, following meals = 500 kcal, independent of fat content.

REFERENCES:

1. Geodon® (ziprasidone) prescribing information. Physician's Desk Reference. 59th ed. Montvale, NJ: Thompson PDR; 2005:2609–2615.
2. Mamo D, et.al. A PET study of dopamine D2 and serotonin 5-HT2 receptor occupancy in patients with schizophrenia treated with therapeutic doses of ziprasidone. Am J Psychiatry. 2004:818–825.

Poster 14 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

SHOULD PSYCHIATRIC SERVICES AND INTERVENTIONS TARGET FAMILY FUNCTIONING IN EFFORTS TO REDUCE THE DURATION OF UNTREATED PSYCHOSIS?

Sandra Goulding, M.P.H., *Project Coordinator, Department of Psychiatry and Behavioral Sciences, Emory University, 49 Jesse Hill Jr. Drive, S.E., Room 333, Atlanta, GA 30303*

SUMMARY:

The duration of untreated psychosis (DUP) is a potentially powerful determinant of the early course of schizophrenia. Research has just begun to investigate predictors of treatment delay, pathways to care, and family involvement in initial help-seeking. Virtually no empirical data exist on the relationship between family functioning and delay in initiating care in first-episode non-affective psychosis. This study hypothesized that family strengths would be inversely correlated with DUP. Family strengths and DUP were assessed in 35 individuals hospitalized for a first episode of psychosis and their family members most involved in initiating care. As hypothesized, family strengths scores were inversely correlated with DUP (?=-.45, p=.01). Family members related to patients with a DUP of =1 year had a significantly higher mean family strengths score than those related to patients with a DUP of >1 year. Given the dearth of research on family functioning in families just beginning to initiate care for first-episode patients, it is imperative to learn more about how family characteristics may impact treatment delay. Additional research is needed to better understand the role that family functioning may play in future psychiatric services and interventions aimed at reducing the DUP.

REFERENCES:

1. Perkins DO, Gu H, Boteva K, Lieberman JA. Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: A critical review and meta-analysis. Am J Psychiatry 2005;2:1785–804.
2. Morgan C, Abdul-Al R, Lappin JM, Jones P, Fearon P, Leese M, et al. Clinical and social determinants of duration of untreated psychosis in the AESOP first-episode psychosis study. Br J Psychiatry 2006;189:446–52.

Poster 15

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

OBSTRUCTIVE SLEEP APNEA IN PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Cheryl Graber, M.D., *Resident, Department of Psychiatry, University of Medicine and Dentistry of New Jersey, 671 Hoes Lane, Room C-205, Piscataway, NJ 08854*; Anthony M. Tobia, M.D.; Anita Mallya, M.D.; Matthew Macaluso, D.O.

SUMMARY:

Objective: To study the prevalence of obstructive sleep apnea (OSA) in patients with severe and persistent mental illness (SPMI) attending a partial hospital program.

Methods: The complaint of excessive daytime sleepiness (EDS) in adults with SPMI attending a partial hospital program will be examined in a systematic manner. Gender, age, weight, body mass index (BMI), neck circumference, blood pressure, current medication, Epworth Sleepiness Scale (ESS) score, psychiatric and medical diagnoses, and use of alcohol and/or illicit substances will be recorded for each patient with EDS. Patients will be referred to a sleep specialist for polysomnography and evaluation of OSA.

Results: The authors found BMI, diastolic blood pressure, and adjusted neck circumference to correlate with severity of OSA. Conversely, average ESS scores were higher in the mild OSA group (10 vs. 9) than in the group with moderate to severe OSA.

Conclusions: Given the impact of OSA on mortality and the propensity of psychotropic medications to cause sedation and weight gain, psychiatrists need to play a de facto role in facilitating the diagnosis and treatment of this condition. Recent literature suggests that the hypoxic events associated with OSA may have detrimental effects on cognitive function and render self-report measures such as the ESS less useful in this patient population. Alternatively, the construction of a screening tool that relies on objective physical signs, such as BMI and adjusted neck circumference, may be of greater benefit to psychiatrists evaluating mentally ill patients with complaints of EDS.

REFERENCES:

1. Caples, SM, et al.:Obstructive Sleep Apnea. Annals of Int Med 2005; 142:187–197.
2. Yaggi, HK, et al.:Obstructive Sleep Apnea as a Risk Factor for Stroke and Death. N Eng J Med 2005; 353(19):2034–2041.

Poster 16

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

LIPID AND GLUCOSE MONITORING OF PATIENTS ON SGAS: ANALYSIS BY AGE GROUP AND SGA

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Daniel Haupt, M.D., *Department of Psychiatry, Washington University School of Medicine, Box 8134, 660 South Euclid, St. Louis, MO 631110*; Lisa Rosenblatt, M.D.; Edward Kim, M.D.; Ross Baker, Ph.D.; Richard Whitehead, B.S.

SUMMARY:

Objective: To compare metabolic monitoring pre- and post-ADA/APA guidelines stratified by age and SGA.

Methods: In this retrospective cohort analysis using PharMetrics data (1999–2006), patients on SGAs (older than 12 years) were identified and followed for 4 months from initial prescription, either preceding or following March 2004. Baseline and 12-week lipid and glucose monitoring were determined for pre- and post-guideline cohorts and stratified by age group and SGA.

Results: 6,777 patients pre-guideline and 6,785 post-guideline were identified. Baseline lipid monitoring was 6.2% pre-guideline and 7.8% post-guideline ($p<0.001$); Week 12 monitoring was 4.6% and 6.3%, respectively ($p<0.001$). Baseline glucose monitoring was 11.6% pre-guideline and 13.2% post-guideline ($p=0.004$); Week 12 monitoring was 8.2% and 10.7%, respectively ($p<0.001$). Adolescents (12–17 years old) had the lowest monitoring rates. Post-guideline, baseline lipid monitoring was 3.0% for adolescents versus 9.0% for adults ($p<0.001$); baseline glucose monitoring was 8.1% for adolescents versus 14.5% for adults ($p<0.001$). Olanzapine had the highest baseline monitoring rates pre-guideline (for baseline lipids, 7.3% vs. lowest 4.2% with ziprasidone, and for baseline glucose, 12.6% vs. lowest 7.9% with ziprasidone). Rates were more similar between drugs post-guideline.

Conclusion: Despite improved rates post-guideline, monitoring of patients on SGAs remains low and differs by age group but not by SGA.

REFERENCES:

1. American Diabetes Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. J Clin Psych 2004; 65:267–272.
2. Cuffel B, Martin J, Joyce AT, Boccuzzi SJ, Ellenor G. Lipid and Glucose Monitoring During Atypical Antipsychotic Treatment: Effects of the 2004 ADA/

APA Consensus Presented at the 58th Institute on Psychiatric Services. October 5–8, 2006, New York, NY.

Poster 17 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

NATIONAL ADHERENCE INITIATIVE IN SCHIZOPHRENIA: ASSESSING THE RISK OF PARTIAL- AND NON-ADHERENCE IN PATIENTS WITH SCHIZOPHRENIA

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Dean Najarian, Pharm. D., BCHP, *Employee, Ortho-McNeil Janssen Scientific Affairs, LLC, 1771 West Street, Wrentham, MA 02093*; John M. Kane, M.D., Mary J. Kujawa, M.D., Ph.D.; Donna Kerney, Ph.D.; R. Bruce Simonson, B.S.; Ramy Mahmoud, M.D.; Xavier Amador, Ph.D.

SUMMARY:

Introduction: A survey tool was developed to identify patients with schizophrenia at risk for partial- or non-adherence.

Methods: The National Adherence Initiative in Schizophrenia is a survey of known non-adherence risk factors. Survey development occurred in 2 phases: a pilot program where physicians/clinicians indicated whether the patient possessed any of 10 risk factor attributes and ranked their importance. Prior to national distribution, the survey was revised to include only 8 attributes and no ranking system. Chi-square analysis identified regional differences; with no adjustment for multiplicity.

Results: "Poor insight into illness" (74%) was the most common and most important attribute reported in the pilot program (309 patients evaluated by 61 physicians/clinicians), followed by "previous discontinuation of medication on own" (68%) and "forgetting medication" (67%). Significant ($p<0.05$) regional differences were found for several attributes. "Poor insight into illness" and "previous discontinuation" were reported by 68% each and "forgotten medication in last 4 weeks" reported by 66% of 13,538 patients evaluated by 1,522 physicians/clinicians in the nationally distributed survey. Nationally, significant ($p<0.05$) regional differences were observed for all risk factors.

Conclusion: This survey tool provides useful descriptive data about the magnitude of adherence issues among patients with schizophrenia allowing clinicians to intervene appropriately.

REFERENCES:

1. Fenton, WS, Blyler CR, Heinssen RK. Determinants of medication compliance in schizophrenia: empirical and clinical findings. Schizophr Bull 1997;23:637–651.
2. Marder, SR. Overview of partial compliance. J Clinical Psychiatry 2003;64(Suppl):3–9.

Poster 18 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

METABOLIC SYNDROME SURVEY IN PSYCHIATRIC OUTPATIENTS LEADS TO LIFESTYLE REVIEWS

J. Daniel Kanofsky, M.D., M.P.H., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Larissa Chismar, B.A.; Mary E. Woesner, M.D.; Maia Mamamtavarishvili, M.D.; Judith Wylie-Rosett, Ed.D.

SUMMARY:

During the summer of 2006, two medical students worked with the staff of the Bronx Psychiatric Center Assertive Community Treatment (ACT) Team and the Ginsburg Outpatient Clinic to evaluate the prevalence of metabolic syndrome and to assess weight-related lifestyle issues. Lifestyle habits were evaluated using a 17-item Quick Weight, Activity, Variety, and Excess (WAVE) Screener. Basic lifestyle counseling was provided with the use of WAVE-oriented counseling sheets. Out of the 41 patients surveyed, 19 of 41 (46%) were obese (body mass index = 30 kg/m2). Among those with sufficient data, 13 of 28 (46%) met the criteria for metabolic syndrome. Noteworthy was that a large number of patients underestimated their weight status and overestimated how healthy they were. For example, 13 of 19 obese patients (68%) perceived their weight as slightly overweight or less. Psychiatric outpatient teams are well suited to educate their patients on improving their physical health. Staff can measure blood pressure and weight monthly and use an instrument such as the Quick WAVE Screener and corresponding educational tools to counsel patients about their diet and activity habits. We will discuss the brief health assessment and intervention tools we used to elicit lifestyle information and counsel patients on wellness goals.

REFERENCES:

1. Soroudi N, Wylie-Rosett J, Mogul D: Quick WAVE Screener: A tool to address weight, activity, variety, and excess. The Diabetes Educator 2004; 30:6–640.
2. Grundy SM, Cleeman JI, Daniels SR, et.al: Diagnosis and management of the metabolic syndrome. An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement. Circulation 2005; 112:2735–2752.

Poster 19 Thursday, October 11
8:30 a.m.-10:00 a.m.

PREDICTORS OF FUNCTIONAL OUTCOMES IN A COMMUNITY EARLY PSYCHOSIS TREATMENT PROGRAM: A PILOT STUDY

Mary W. Lu, M.D., *Psychiatry Fellow, Department of Psychiatry, Portland VAMC, 2908 N.W. Thurman Street, Portland, OR 97210*; Bentson McFarland, M.D.; Brigid Zani, M.A.; Tamara Sale; Robert M. Wolf, M.D.; Ryan Melton

SUMMARY:

Purpose: Assess functional outcomes in community-based early psychosis treatment and identify predictive factors.

Background: EAST (Early Assessment and Support Team) is a community early psychosis treatment program developed with evidence-based guidelines.

Methodology: Clients enrolled in EAST for at least 12 months by March 2005 were included (n=87, mean age=21). Dichotomized outcomes included: 1.) Level of independent living; 2.) Working or in school; and 3.) Hospitalization during that quarter. Missing data (n=34) on independent living was obtained retrospectively. Logistic regression was used to identify correlations between outcome measures and clinical independent variables.

Results: At 12 months, 32% had a normal level of independent living and 49% were working or in school. Clients without previous substance use were 5 times more likely to be working or in school. Hospitalization correlated negatively with marriage.

Importance: Functional outcomes reflect the impact of psychosis and treatment; previous outcome studies have not always examined them.

Summary: Challenges to functional gains are significant. Previous drug use predicts lower likelihood of working or being in school after treatment for early psychosis, and may reflect previous biological or environmental effects.

REFERENCES:

1. McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ. "EPPIC: an evolving system of early detection and optimal management." Schizophr Bull. 1996;22(2):305–26.
2. Malla, Ashok, and Jennifer Payne. "First-Episode Psychosis: Psychopathology, Quality of Life, and Functional Outcome." Schizophrenia Bulletin, vol. 31, no. 3, 650–671, 2005.

Poster 20 Thursday, October 11
8:30 a.m.-10:00 a.m.

THE IMPACT OF A MODIFIED INPATIENT DIET AT DIFFERENT DOSES OF OLANZAPINE

Charles S. Nguyen, M.D., *Assistant Professor, Department of Psychiatry, University of California, Irvine, 101 City Drive, Orange, CA 92868*

SUMMARY:

Objective: Olanzapine can cause significant weight gain, which may correlate with dose. In an attempt to decrease weight gain, UCI's Acute Psychiatric Unit introduced an inpatient diet program in 2003 that eliminated double portions, desserts, sodas and high caloric snacks. This retrospective study analyzes weight changes of patients treated with three dose ranges of olanzapine while receiving the modified diet.

Methods: An electronic review of patients at the UCI Acute Psychiatric Unit from 2003–2006 was performed. Patients with schizophrenia or schizoaffective disorder treated with olanzapine were selected. ANOVA and Tukey HSD testing was used to compare differences between groups.

Results: Three olanzapine dose ranges were compared: >=30mg, 20–29mg, and <=15mg. Patients in the >=30mg group (N=38) gained an average of 5.9 lbs. The 20–29mg group (N=36) gained 3.9 lbs. The <=15mg group (N=21) lost 0.9 lb. Differences between the >=30mg group and <=15mg group were statistically significant (P=0.04). Average treatment time was 19 days in the >=30mg group and 22 days in the 20–29mg and <=15mg groups (P=NS).

Conclusions: Inpatient diet modifications may reduce the potential for olanzapine-induced weight gain when olanzapine doses are 15mg or less. Higher olanzapine doses appear to be associated with greater weight gain.

REFERENCES:

1. Lieberman, J.A., Stroup, T.S., McEvoy, J.P., et.al. Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia. New England Journal of Medicine, 2005; 353:1209–23.
2. Wirshing DA, Wirshing WC, Kysar L et.al. Novel antipsychotics: comparison of weight gain liabilities. Journal of Clinical Psychiatry 1999; 60–358–363.

Poster 21 Thursday, October 11
8:30 a.m.-10:00 a.m.

COGNITION/FUNCTIONAL OUTCOMES IN SCHIZOPHRENIC PATIENTS: A PATH ANALYTIC APPROACH

Supported by Eli Lilly and Company

Chintan Patel, Pharm.D., *Outcomes Liaison, Medical Division, Eli Lilly and Company, Lilly Corporate Center,*

DC 5024, Indianapolis, IN 46285; Ilya Lipkovich, Ph.D.; Walter G. Deberdt, M.D.; John G. Csernansky, M.D.; Bernard Sabbe, M.D.; Richard Keefe, Ph.D.

SUMMARY:

Objective: To evaluate the relationships among cognition, psychopathology and functioning at baseline and following treatment for 24 weeks.

Methods: Data were obtained from a clinical trial assessing neurocognitive efficacy in patients with schizophrenia randomized to olanzapine (n=159), risperidone (n=158), or haloperidol (n=97). Functioning was assessed with the Heinrichs' Quality of Life Scale; cognition with a standard battery of neurocognitive tests, psychiatric symptoms with the Positive and Negative Syndrome Scale (PANSS). A path analytic approach was used to evaluate the effect of cognitive functioning on subdomains of quality of life, whether direct or mediated via psychiatric symptoms.

Results: At baseline (N=395), processing speed affected functioning indirectly via PANSS negative subscale score and directly for interpersonal functioning. Working and verbal memory did not significantly contribute to the path analytic models. Similarly, at 24 weeks (N=208), changes in processing speed affected changes in functioning both directly and indirectly via changes in PANSS negative subscale score. Results varied somewhat across the three functional domains.

Conclusions: An indirect relationship mediated via psychiatric symptoms was observed between cognition and functioning at baseline. Changes in cognition had a mild impact on changes in functioning mediated via changes in negative symptoms.

REFERENCES:

1. Keefe RS, Young CA, Rock SL, Purdon SE, Gold JM, Breier A; HGGN Study Group. One-year double-blind study of the neurocognitive efficacy of lanzapine, risperidone and haloperidol in schizophrenia. Schizophr. Res; 81: 1–15.
2. Green MF, Kern RS, Braff DL, Mintz J. Neurocognitive deficits and functional outcome in schzophrenia: are we measuring the ''right stuff''? Schizophr Bull 2000; 26:119–136.

Poster 22 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

INITIAL PSYCHOSIS IN A RECENT CARIBBEAN IMMIGRANT TO THE U.S.A.

Sarkar Priyankar, M.D., *Psychiatry Intern, Department of Psychiatry, Albert Einstein Medical Center, 5501 Old York Road, Philadelphia, PA 19130-3601*

SUMMARY:

A 30 year old African male, unemployed, with no significant past psychiatric history was admitted on a 201 for threatening to kill his mother, sister and brother. The patient had recently moved from Jamaica to the U.S.A. three months ago and since then had always kept to himself having minimal contact with his relatives. Four days prior to admission, the patient had left home in the morning unannounced and he was brought in the next morning by the police when he was found lying on the streets. On the day of admission, per mom, ''he started behaving weird in the evening''. He attacked his sister and had to be held back by his brother. No significant information was gleaned in the past psychiatric, or past medical history. A couple of interesting facts were obtained from psychosocial history as follows: Patient's mom moved to U.S ten years ago leaving him with his dad in Jamaica and used to visit him once every year. He was thrown out of his house two years ago since his dad's girlfriend moved in and since then, was living between the streets and his uncle's home. Patient was very close to his dad, but hadn't spoken to him since two years since the incident. Patient is currently unemployed but used to paint cars in Jamaica before moving. On initial mental status examination, patient had flat affect, thought blocking; speech had perseverations ''yes sir'', never made eye contact during the entire interview and broke down in tears thrice during the intake. We spoke to the sister the following day and learned that patient had intermittent episodes in Jamaica where he had excessive energy, decreased sleep, used to keep himself busy in a lot of activities. An initial working diagnosis of Bipolar Disorder, most recent episode depressed with psychotic features, r/o psychosis NOS, r/o adjustment disorder was made and the patient was started on mood stabilizer (lithium) and an atypical antipsychotic (Risperidol). Over the course of the next week, patient was getting more responsive to questions, but was still keeping to himself most of the time. The episode of psychotic outbreak was observed on being moved to another unit where he started shouting and was very agitated. Throughout his hospital course, the predominance of negative symptoms made us question our initial working diagnosis . It was decided to discountinue lithium and to treat this as schizophreniform disorder and the atypical was changed. It was an interesting debate as to whether immigration was a trigger for his decompensation, or was he a severe case of cultural shock for an immigrant, or he had negative symptoms of schizophrenia before which were not noticed, or being in a psychiatric hospital within a month of immigration lead to a collapse of his defenses. There were several other

possibilities that made it such an interesting case worth a full discussion.

REFERENCES:

1. Incidence of schizophrenia or other psychoses in first- and second-generation immigrants: a national cohort study. Journal of Nervous & Mental Disease. 194(1):27–33, 2006 Jan.
2. Increased risk of psychotic disorder among immigrants in Malmo: a 3-year first-contact study. Psychological Medicine. 35(8):1155–63, 2005 Aug.

Poster 23 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

MODAFANIL IN DEFICIT SYNDROME SCHIZOPHRENIA

Karen Richardson, M.S., *Instructor, Division of Psychopharmacology and Clinical Trials, Department of Psychiatry and Human Behavior, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216*; Joseph Kwentus, M.D.

SUMMARY:

Objective: Negative symptoms significantly limit the functional capacity of people suffering from schizophrenia and are often refractory to treatment. The authors examined Modafinil as an adjunctive treatment for people with schizophrenia who also have prominent negative symptoms.

Method: Six patients with deficit syndrome schizophrenia were enrolled in a double-blind, placebo-controlled, cross-over designed clinical trial of Modafinil for the treatment of negative symptoms. The predetermined primary outcome scale was the Negative Symptom Assessment Scale. Secondary outcome measures included the Schizophrenia Quality of Life Questionnaire, the Positive and Negative Syndrome Scale, and the Clinical Global Improvement Scale.

Results: Treatment with Modafinil improved patients' negative symptoms when compared to placebo. (P=.04). Although not statistically significant, the secondary outcome measures: Positive and Negative Syndrome Scale—Negative Symptoms, Clinical Global Improvement, and the Schizophrenia Quality of Life Questionnaire also changed in a direction that supported the hypothesis.

Conclusions: Modafinil may benefit patients with schizophrenia who have negative symptoms when it is added to antipsychotic treatment regimens. Limitations of the study include the small sample size, which may have increased the likelihood of a type II statistical error. An extended study period with a larger sample would further evaluate that efficacy is maintained without compromised safety.

REFERENCES:

1. Rosenthal MH, Bryant SL: Benefits of adjunct modafinil in an open-label, pilot study in patients with schizophrenia. Clin Neuropharmacol 2004 (Jan-Feb):38–43.
2. Turner DC, Clark L, Pomarol-Clotet E, McKenna P, Robbins TW, Sahakian BJ: Modafinil improves cognition and attentional set shifting in patients with chronic schizophrenia. Neuropsychopharmacology 2004(Jul):1363–73.

Poster 24 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

EFFICACY OF DEPOT RISPERIDONE IN REDUCING INPATIENT READMISSION RATES

Ajay Sharma, M.D., *Resident, Department of Psychiatry, Delaware Psychiatric Center, 1901 N. DuPont Highway, New Castle, DE 19720*; Karen Kovacic, M.D.

SUMMARY:

Objective: We studied the efficacy of long acting, injectable risperidone, the first available atypical depot antipsychotic, in reducing inpatient psychiatric readmissions in persons with schizophrenia.

Methodology: Persons who were admitted to the acute care unit of a public-funded inpatient psychiatric hospital were screened for non-adherence with their pharmacological treatment. Those who were non-adherent and, when it was not contraindicated, were started on long acting, injectable risperidone. Records were reviewed for the number of inpatient psychiatric admissions for a period of one-year pre-and one-year post-initiation on long acting risperidone. Psychiatrists determined the dose of risperidone including the choices of 25mg, 37.5mg and 50mg intramuscular every two weeks. At the time of this study the 12.5mg dose of risperidone was not FDA approved.

Results: Mean number of admissions in 41 subjects in one-year pre- and post-initiation of resperidone was 3.46 and 0.88 respectively (p=0.000). Twenty-four out of 41 (58.5%) were not re-admitted in one-year post initiation of risperidone. The differences of age, sex, or race of the subjects or the dose of risperidone were statistically insignificant.

Conclusion: Long acting, injectable risperidone is effective in reducing the inpatient psychiatric unit readmission rate in this convenience sample of individuals with schizophrenia.

REFERENCES:

1. Adams, C.E., et.al., Systematic meta-review of depot antipsychotic drugs for people with schizophrenia. Br J Psychiatry, 2001. 179: p. 290–9.
2. Weiden, P.J. and M. Olfson, Cost of relapse in schizophrenia. Schizophr Bull, 1995. 21(3): p. 419–29.

Poster 25 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

SUPPORTED EMPLOYMENT AT A STATE PSYCHIATRIC HOSPITAL: INITIAL PROGRAM RESULTS

Steven L. Webster, M.Div., *Psychosocial Rehabilitation Director, Rehabilitation Services, Dorothea Dix Hospital, 3601 MSC Center, Raleigh, NC 27699*; Shirley Kelly

SUMMARY:

Background: "Work therapy" (WT) is a prescribed intervention commonly used at state psychiatric hospitals. This presentation describes programmatic results of a 339 bed state hospital's movement away from WT to evidence-based supported employment (SE) principles and practices.

Methods: 1.) Viability and safety analyses were completed for all existing and potential hospital worksites and jobs for clients; 2.) A program budget was established; 3.) Employment specialists were assigned and trained in principles and practices of SE; 4.) A human resources structure was introduced including procedures for posting jobs, interviewing, hiring/firing and counseling workers; and 5.) Payroll samples were collected from a month prior to and one year after implementing the program.

Results: Ten classifications, 7 worksites, and 43 job positions were assessed as "viable" (real jobs that supported facility operations). This was a 19% decrease in positions compared with the former WT program. The new program had a total of 71 positions (61% SE and 39% prescribed transitional employment). The payroll samples showed an average decrease of 347 hours paid to workers per week. The program was projected to meet its first year budget.

Conclusion: It is programmatically feasible for a state hospital to use supported employment principles and practices.

REFERENCES:

1. Bond GR, Becker DR, Drake RE, et.al: Implementing supported employment as an evidence-based practice. Psychiatric Services 52: 313–322, 2000.
2. Drake RE, Goldman HH, Leff HS, et.al: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 52:179–182, 2001.

Poster 26 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

CHANGE IN AKATHISIA WITH ILOPERIDONE, RISPERIDONE, OR PLACEBO DURING AN EFFICACY TRIAL

Supported by Novartis Pharmaceuticals and Vanda Pharmaceuticals

Curt Wolfgang, Ph.D., *Director, Clinical Programs, Vanda Pharmaceuticals, 9605 Medical Center Drive, Suite 300, Rockville, MD 20850*; Paolo Baroldi, M.D., Ph.D.; Peter J. Weiden, M.D.

SUMMARY:

Introduction: Akathisia was assessed as part of a placebo- and risperidone-active-controlled, efficacy and safety study of iloperidone.

Methods: The Barnes Akathisia Scale (BAS) and the Extrapyramidal Symptom Rating Scale (ESRS) were used to assess change in akathisia from baseline to 6-week endpoint for patients receiving iloperidone (12-mg/d or 20–24 mg/d), risperidone (6–8 mg/d), or placebo. Categorical analyses were conducted to determine the percentage of patients with akathisia that worsened, remained unchanged, or improved.

Results: Both iloperidone groups had statistically significantly fewer patients whose total BAS score worsened compared with the placebo group. All BAS subscale change scores of the risperidone group were comparable to those of the placebo group. Statistically significantly fewer patients receiving iloperidone 12-mg/d had worsening in the akathisia subscale score of the ESRS compared with those receiving placebo, and there was a nonsignificant trend favoring the iloperidone 20–24 mg/d treatment group over the placebo group. Percentage of patients with worsening ESRS akathisia subscale scores in the risperidone group was comparable to that in the placebo group.

Conclusion: Both doses of iloperidone appeared to have a low propensity to cause akathisia. Iloperidone may offer an additional treatment option for schizophrenia with a favorable akathisia tolerability profile.

REFERENCES:

1. Kalkman HO, et.al. Neuropsychopharmacology. 2001;25:904–914.
2. Subramanian N, et.al. Prog Neuropsychopharmacol Biol Psychiatry. 2002;26:553–560.

Poster 27 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

INTERPLAY OF DEPRESSION AND PSYCHOSIS IN OLDER ADULTS WITH SCHIZOPHRENIA

Supported by the National Institute of General Medical Sciences

Shilpa P. Diwan, M.D., *Clinical Assistant Professor, Department of Psychiatry, State University of New York, Downstate Medical Center, 415 100th Street, Second Floor, Brooklyn, NY 11209-8308*; Carl I. Cohen, M.D.; Paul M. Ramirez, Ph.D.

SUMMARY:

Objective: The literature suggests that there is a core group of schizophrenic persons who suffer from psychosis with concomitant depression. Older schizophrenic persons provide an opportunity to examine this issue because the disorder has attained its most developed and complex forms.

Methods: We used a stratified sample, drawn from residential programs and clinics in New York City that consisted of 198 schizophrenia persons aged 55+ who developed the disorder prior to age 45. We examined 2 levels of depression: ''syndromal'' and ''subsyndromal/ syndromal'' that were defined as >16 and > 8 on the CESD sacle, respectively. ''Psychosis was based on scoring >3 on any of the PANSS items for hallucinations, delusions, or conceptual disorganization. Using 17 independent variables, we contrasted 4 categories: 1.) No depression/no psychosis; 2.) Depression/no psychosis; 3.) No depression/psychosis; and 4.) Depression/psychosis. The groups were compared using bivariate analyses, and then multinomial regression analysis.

Results: With syndromal depression, the percentage in categories 1,2,3,4, were 53,19,14, and 14, respectively. With subsyndromal/syndromal depression, the percentage in categories 1,2, and 3 from category 4, and for subsyndromal/syndromal depression, 9 variables were signinficant. Significant variables included cognitive functioning, education, family history of depression, number of lifetime hospitalizations, number of physical disorders, acute stressors, and propotion of confidents, PANSS negative scale, use of spiritualists, psychiatric services, and number of psychotropic medications.

Conclusions: Although longitude studies are needed to examine causual directionality, our findings suggests that because a variety of clinical and psychosis variables are associated with differences among the various categories, the notion of a core group of psychosis/depressed may not be warranted. The implications for research and treatment will be discussed.

REFERENCES:

1. An der Hieden W, Konnecke R, Maurer K, Ropeter D, Hafner H: Depression in the long-tern course of schizophrenia; Eur Arch Psychiatry Clin Neurosci. 2005 Jun;255(3):174–84.
2. Koreen AR, Siris SG, Chakos M, Alvir J, Mayerhoff D, Liebermand J: Depression in first episode schizophrenia; AM J Psychiatry. 1993 Nov;150(11): 1643–8.

Poster 28 **Thursday, October 11**
8:30 a.m.-10:00 a.m.

SUICIDE IN OLDER ADULTS WITH SCHIZOPHRENIA: SPECTRUM DISORDERS

Supported by the National Institute of General Medical Sciences

Shilpa P. Diwan, M.D., *Clinical Assistant Professor, Department of Psychiatry, State University of New York, Downstate Medical Center, 415 100th Street, Second Floor, Brooklyn, NY 11209-8308*; Paul M. Ramirez, Ph.D.; Pia N. Reyes, M.D.; Ipsit V. Vahia, M.D.; Mamta Sapra, M.D.; Azziza O. Bankole, M.D.; Carl I. Cohen, M.D.

SUMMARY:

Objective: To determine the prevalence of current suicidality and prior sucidual attempts in older adults with schizophrenia and examine associated factors.

Methods: The Schizophrenia Group(s) consisted of 198 persons aged 55+ living in the community who developed schizophrenia before age 45. We excluded persons with substantial cognitive impairment. A Community Comparision Group (C) (n=113) was selected which closely matched the schizophrenia sample. We examined current suicidality (presence of the following in the past 2 weeks: wishing to be dead, thoughts of suicide, or attempted suicide) and lifetime history of a suicidal attempt. For S, we used Geourge's Social Antecedote Model to examine 16 predictors of attempted suicide.

Results: We found a higher prevalence of current suicidality among S when compared to C (10% versus 2% p=.006), as well as past suicidal attempts (30% versus 4%; p=.001). We seperately examined S. 19% of those who previously attempted suicide. 55% of those who currently expressed suicidality had previously attempted suicide. 55% of S who had previously attempted suicide currently had syndromal drepression (CESD> 16) versus 27%, who had never attempted suicide (p= .01); among those who currently expressed suicidality (p=.001). In logic regression, we found 3 significant predictors of previous suicide attempts: current syndro-

mal depression (OR=2.36), number of lifetime traumatic events (OR=.1.16), and diminished use of spiritualists (OR=.44).

Conclusions: Prevalence of current suicidality and previous suicide attempts is dramatically higher among older schizophrenic adults than their peers in the community. Schizophrenic persons with prior attempts continue to express suicidality and exhibit more depression. Risk factors for previous attempts include current importance of monitoring for suicidality, obtaining a detailed sucidal history, and the potential value of pharmacotherapy for depression and psychotherapy for prior traumatic events.

REFERENCES:

1. Montross LP, Zisook S, Kasckow J.: Suicide among patients with Schizophrenia: A Consideration of Risk and Protective Factors. Ann Clin Psychiatry. 2005 Jun-Sep;17(3):173–82.
2. Barak Y, Knobler CY, Aizenberg D: Suicide Attempts Amongst Elderly Schizophrenia Patients: A 10-Year Case-Control Study. Schizophr Res. 2004 Nov 1;71(1):77–81.

Poster 29 **Thursday, October 11 8:30 a.m.-10:00 a.m.**

THE RELATIONSHIP OF DEPRESSION/ PSYCHOSES AND FUNCTIONING IN OLDER SCHIZOPHRENIC ADULTS

Supported by the National Institute of General Medical Sciences

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

SUMMARY:

Background: Studies show varying relationships of positive symptoms, negative symptoms, and depression on cognitive functioning. Older adults with schizoprenia in the study were categorized based on the presence or absence of psychoses and depression. We examined the association between these categories and measures of functioning.

Methods: The sample consisted of a stratified convenience sample of 198 community-dwelling schizophrenic (S) persons aged 55= in residential and nonresidential settings. 113 persons comprised a matched comparision group (C). The independent variable consisted of 4 categories of depression/positive symptoms based on cut-off scores on the PANSS and the CESD. The dependent variables consisted of the 5 subscales and the total score on the Deminita Rating Scale, the Instrumental Activities of Daily Living scale, and the number of confidants.

Results: The S subgroups scored singificantly worse than the C group on the IADL scal, number of confidants, and all scales of the DRS. In the subcategories of the S group, there were significante group differences on the DRS Concetualization, DRS total and number of confidants. Groups without positive symptoms scored higher than the groups with positive symptoms, regardless of the presence of depression. When the group was dichotomized (with and without positive symptoms), those with positive symptoms had significantly lower scores in the DRS scales for Memory, Initiation/Perservation, DRS Conceptualization, total DRS score and number of confidants. After controlling for negative symptoms (because of a significant correlation between the PANSS positive and PANSS negative symptom scales), only two retained significance: DRS Conceptualiztion Subscale and DRS Total.

Conclusion: All S groups were more impaired when compared to the general community and those persons with positive symptoms had the greatest impairment. Being depressed without psychoses was not associated with any additional functional impairment. These findings suggest that positive symptoms may have more impact on functional status.

REFERENCES:

1. Harvey PD, et.al: The Course of Functional Decline in Geriatric Patients with Schizophrenia. Am J Geriar Psych 2003;11:610–613.
2. Bowie CR, Reichenberg A, Patterson TL, Heaton RK, Harvey PD: Determinants of Real-World Functional Performance in Schizophrenia Subjects: Correlations with Cognition, Functional Capacity, and Symptoms. Am J Psychiatry 2006; 163:418–425.

POSTER SESSION 2

Posters 30–58
Thursday, October 11
3:00 p.m.-4:30 p.m.

SERVING THE COMMUNITY

Poster 30 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

INTEGRATION OF PSYCHIATRIC SERVICES IN TREATING PATIENTS WITH HCV AND OPIATE DEPENDENCE

Ann B. Beeder, M.D., *Medical Director, Vincent P. Dole Institute, 445 E. 68th Street, Office 1A, New York, NY*

10021-6330; Anthony Martinez, M.D.; Erin M. Hays, M.S.W.; Kim Alexander, M.S.W.

SUMMARY:

This research project focuses on the provision of an integrated treatment approach to Hepatitis C patients at the Vincent P. Dole Institute for Research and Treatment of Opiate Dependency of the Weill Cornell Medical College and the New York Presbyterian Hospital. The Institute consists of two methadone clinics that provide treatment services to a population of 300 opiate addicted patients. Upon admission patients are evaluated for Hepatitis C and co-morbid psychiatric disorders. 80% of the patient population has been found to be HCV seropositive with co-morbid psychiatric conditions. At the clinic level the patients receive adequate dosages of methadone for their opiate dependency, as well as psychiatric services provided by the clinics' psychiatric and social work staff. Hepatitis C treatment is provided in close collaboration with the Hospital's Hepatitis C physicians under the coordination and supervision of the Institute's Medical Director, who is a psychiatrist, Therefore, the treatment services are integrated in a manner that allows for an efficient, patient-centered, cost effective delivery of health care. Early results indicate: reduction of psychiatric barriers to treatment readiness and increased treatment and medication adherence; decreased rate of hospitalizations; reduction of risky behaviors and improved quality of life.

REFERENCES:

1. Beeder AB, Millman RB, Patients with psychopathology. In: Lowinson JH, Ruiz P, Millman RB, Langrod JG, eds. Substance Abuse A Comprehensive Textbook. Third edition. Baltimore: Williams & Wilkins, 1997:551–563.
2. Alter MJ, Kruszon-Moran D, Nainan OV, et.al. The prevalence of hepatitis infection in the United States, 1988 through 1994, New England Journal of Medicine 1999;341(8);556–562.

Poster 31 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

BURNOUT IN THE HEALTH TEAM

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Robert Sessa, M.Psy.; Paula Kioroglo, M.Psy.

SUMMARY:

It has been proven in new studies that there is a need to dedicate greater attention to the health of health care professionals. It is part of these professionals' daily lives to work under great stress and deal with diseases, pain and suffering, and the emotional stress in their work relations is an important factor in the determinations of syndromes regarding depression, stress and Burnout Syndrome. The aims of this investigation were to identify the presence and influence factors for the appearance of Burnout Syndrome in health professionals from Santa Casa de São Paulo, as well as classify this population social-demographically and investigate the incidence of depression. A descriptive transversal research was done involving 3 professionals (92,1% of the population) from the three shifts of the Strategic Health Units from Santa Casa de São Paulo: Medicine, Surgery, Surgical Technique and Experimental Surgery. They filled out the research protocol, which consists of a social-demographical form and the following instruments: MBI - Maslach Burnout Inventory, ICT – Work Context Inventory and BDI - Beck Depression Inventory. The SPSS for Windows program, 13.0 version was used for the statistical evaluation. The sample is made of 50 professionals that work as nurses (,6%), 198 assistant nurses (65,6%), 18 administrative assistants (6,0%), 31 workers (10,3%), 2 transport agents (0,7%) and 3 with other functions (1,0%). The participants' average age is 36,10 years (average deviation = 9,211), where 17,8% are male and 82,2% female. The sample pointed out that the work context contributes to professional stress in a certain level; 31,6% present some level of Depression and 54% of the professionals had an above average value regarding Burnout Syndrome. It can be concluded that the professional exhaustion is becoming an insidious epidemic, imposing demands that are above the adjustment capacity, hence altering efficiency, health, creativity, capacity of studying, the will to see patients and therefore becoming a source for the suffering of the health professional. There is an imminent need to establish preventive and care actions for the health professional.

REFERENCES:

1. Maslach H C., Entendendo o Burnout. Em Rossi, A. M.; Perrewé P. L. & Sauter S. L., Stress e Qualidade de Vida no Trabalho: Perspectivas Atuais da Saúde Ocupacional. São Paulo. Atlas, 2005.
2. Nogueira-Martins L. A., A Saúde do Profissional da Saúde. Em De Marco, M. A. (Org.) – A Face Humana da Medicina: Do Modelo Biomédico ao Modelo Biopsicossocial. São Paulo. Casa do Psicólogo, 2003.

Poster 32 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

THE IMPACT OF PLAYING ON THE STRESS AND THE HEALTH OF HOSPITALIZED CHILDREN

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112,*

Sao Paulo, Brazil 01221-900; Claudia Mussa, B.S.; Fani Malerbi, Ph.D.; Maria das Gracas Lima, M.Psy.; Adriana Fregonese, M.Psy.

SUMMARY:

Objective: The hospitalization for children can be considered a stress situation. Many groups have done activities to change the humour of hospitalized children. The objetive of this study was weigh up the impact of playing, made by a group called Story Tellers, on the hospitalized children emotional situation and their pain complaining.

Methods: The participants were 24 children with cancer, admitted to the Santa Casa's Pediatrics of São Paulo, and their parents. On the first part, the behaviour of nine children (5-years old) were observed during the time they received the Story Tellers visit and when this visit didn't happen. Based on this first part, the second part instruments were draw up. On the second part, the parents of the 15 children were interviewed and the children (5–10 years old) were observed before, during and after the Story Tellers visit. Children also classified their pain in a Pain Scale, before and after the Story Tellers visit.

Results: The results showed that, after the Story Tellers visit, most part of children talked more than before with they parents, with other hospitalized children and with the health professionals; they were calmer than before, during the medical procedures. Children reduced their pain complaining, they growed up their movements in the ward, and their appetite was better than before the Story Tellers visit.

Conclusions: It showed that the playing had a good effect on hospitalized children health.

REFERENCES:

1. Botega, N. J. & Smaira, S. I. – Morbidade Psiquiátrica no Hospital Geral. In: Botega, N. J. (Org.), Prática Psiquiátrica no Hospital Geral: Interconsulta e Emergência. Artmed. São Paulo, 2002.
2. De Marco, M. A. (Org.) – A Face Humana da Medicina: Do Modelo Biomédico ao Modelo Biopsicossocial. Casa do Psicólogo. São Paulo, 2003.

Poster 33 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

SPEAKING OUT FOR MENTAL HEALTH: COLLABORATION BETWEEN FUTURE PSYCHIATRISTS AND JOURNALISTS

Jamae C. Campbell, M.D., *Department of Psychiatry, University of South Carolina, 1424 Franklin Street, Columbia, SC 29201*; Nioaka N. Campbell, M.D., Jennifer E. Heath, M.D.; Brian S. Dundas, M.D.; Laura G. Hancock, D.O.; Ralph C. Pollock, M.D.; Jesse A. Raley, M.D.

SUMMARY:

Media outlets are the leading genre by which public opinion is formed. Reservations and discomfort with media interactions are common explanations for psychiatrists' lack of participation in advocacy. The primary goals of this project, funded by a state association grant from the American Psychiatric Association, were to change attitudes and understanding of mental illness within journalists in training, and to improve confidence in media interactions among psychiatry residents. Attitudinal surveys among rising journalists regarding psychiatry/mental illness, and psychiatry residents concerning comfort with the media were obtained. Designated speakers/workshop leaders from each discipline modeled appropriate, professional interactions. Interdisciplinary teams were assigned competitive group projects for developing an advocacy campaign over a 6 month period. Results included a demonstrated increase from 14% to 64% in resident comfort with media interactions and an increase from 60% to 100% in journalists' recognition of stigma as a major problem for mental health. This project demonstrates the effectiveness of an interdisciplinary curriculum in improving attitudes/knowledge among representatives of the media, psychiatry, and mental health. This project focused on future media journalists and psychiatrists, making an early impact on those same individuals who will be handling crucial issues of mental health and advocacy in the future.

REFERENCES:

1. Kaliebe K and Sondheimer A: The media: relationships to psychiatry and children. Academic Psychiatry 2002; 26:205–215.
2. Sacketta DL, Haynes RB, Guyatt GH and Tugwell P: Dealing With The Media. J Clin Epidemiol. 2006; 59(9):907–913.

Poster 34 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PERCEPTIONS OF BODY WEIGHT AND PHYSICAL HEALTH IN TWO OUTPATIENT PSYCHIATRIC POPULATIONS

Larissa Chismar, B.A., *Medical Student, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, NY 10461*; Christian Escobar, B.S.; Mary E. Woesner, M.D.; Maia Mamamtavarishvili, M.D.; Judith Wylie-Rosett, Ed.D.; J. Daniel Kanofsky, M.D.

SUMMARY:

Psychiatric patients are at greater risk for obesity, in part because of their use of psychotropic drugs. They may have limited insight into their own health and have difficulty assessing whether their weight is healthy.

Method: Surveys were administered to 41 patients in two outpatient settings at Bronx Psychiatric Center: Assertive Community Treatment (ACT) and the Ginsberg Outpatient Clinic. These surveys sought to assess patients' diet and exercise habits and beliefs about their weight and health. Measurements of height and weight were taken to calculate Body Mass Index (BMI). Obesity was defined as a BMI = 30 kg/m2.

Results: 19 of 41 patients (46%) were obese; 13 of 19 obese patients (68%) perceived their weight as slightly overweight or less; and 11 of the 19 obese patients (58%) thought their health was "good" or better.

Conclusion: Many patients did not base assessment of weight and overall physical health on their actual weight. Patients may need education and correction of misperceptions before they enter a weight loss or health improvement program.

REFERENCES:

1. American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27(2):596–601.
2. Soroudi N, Wylie-Rosett J, Mogul D: Quick WAVE Screener: A tool to address weight, activity, variety and excess. The Diabetes Educator 2004; 30(4):6–640.

Poster 35 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

EXTENDED SURREPTITIOUS INGESTION OF RAT POISON IN A 20 YEAR OLD DEPRESSED FEMALE

James Cho, M.D., B.S., *Chief Resident, Department of Psychiatry, UMDNJ-Robert Wood Johnson Cooper Hospital, 1 Cooper Plaza, Camden, NJ 08103*; Safeer A. Ansari, D.O.

SUMMARY:

Ingestion of rat poison to commit suicide is rare in the western world with few documented cases in literature. The wide availability of rat poison, lack of barriers in obtaining this product, difficulty in detecting symptoms of bleeding secondary to its ingestion, rarity in the use of a superwarfarins for suicide, and extended duration of the half life of superwarfarins make ingestion of superwarfarins in suicide attempts a diagnostic and therapeutic challenge for psychiatry. In this case, a 20 year old had ingested rat poison, more specifically broudifacoum, to commit suicide. This case presents the difficulties with treating a suicidal patient that self ingested rat poison for a period of several months on more than one occasion with a psychiatric, emergency medicine, toxicological and medical perspective. Also included are suggestions based on a consensus of the few other cases where rat poison was ingested for the purpose of suicide.

REFERENCES:

1. Su Mark, Hoffman R: Anticoagulants. Goldfrank's Toxocologic Emergencies Eigth Edition 2006; 891–894.
2. Gibson A: Non-adherence in a depressed psychiatric patient: a case with potentially fatal consequences. Psychiatrysource.com; http://www.psychiatrysource.com.psychsource/Case_Studies/article-1756.htm.

Poster 36 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PSYCHIATRIC COMPLICATIONS OF MALARIA FALCIPARUM INFECTION: A CASE REPORT

Catherine Chung, B.A., *Medical Student, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Room 1702UH, Syracuse, NY 13210*; Adekola O. Alao, M.D.; Mantosh Dewan, M.D.

SUMMARY:

Here we report a case of malaria where the presentation and sequelae included psychiatric complications. The patient is a 37-year-old African American physician without any significant past medical or psychiatric history who presented with sudden onset of fever, chills, headache, nausea, vomiting, and decreased urine output. In addition, he reported marked irritability and limited frustration tolerance. The symptoms began seven days after the return from a two-week trip to West Africa. A review of systems was positive only for dark urine that was reduced in volume. A blood smear taken in the emergency room revealed ring forms of malaria parasites consistent with falciparum malaria at 82,000/microliter. The patient was admitted with a diagnosis of falciparum malaria complicated by acute renal failure. He was treated with doxycycline IV and oral quinine for three days. He was rehydrated with normal saline and transfused with six units of platelets. His renal function improved rapidly, and he was discharged four days after

hospitalization. Doxycycline 100mg po BID was continued for another three days following discharge. BUN and creatinine continued to fall steadily and reached normal values two weeks after discharge. Two weeks later, however, the patient noticed increased apathy and depression that was accompanied by irritability, low frustration tolerance, reduced appetite, insomnia, anhedonia, and reduced energy. He denied decreased concentration, as well as feelings of guilt or suicidal or homicidal ideation. He was diagnosed with adjustment disorder with depressed mood and was treated with brief psychotherapy. The patient responded well with improvement in his mood, sleep, and appetite, as well as decreased irritability. He did not require treatment with antidepressants nor psychiatric hospitalization.

REFERENCES:

1. Dugbartey AT, Dougeartey MT, Apedo MY. Delayed neuropsychiatric effects of malaria in Ghana. Journal of Nervous and Mental Disorders. 1998;186:183–186.
2. Varney NR, Roberts RJ, Springer JA, Connell SK, Wood PS. Neuropsychiatric sequelae of cerebral malaria in Vietnam veterans. Journal of Nervous and Mental Disorders 1997; 185:695–703.

Poster 37 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

NEGATIVE SYMPSTOMS AND QUALITY OF LIFE: A RANDOMIZED, 196-WEEK, DOUBLE-BLIND STUDY OF ZIPRASIDONE VERSUS HALOPERIDOL

Supported by Pfizer Inc.

Gary L. Ellenor, Pharm.D., *Medical Director, Neuroscience, Pfizer Inc., 5368 Hewlett Drive, San Diego, CA 92115*; Stephen M. Stahl, M.D.; Ashok K. Malla, M.D.; John W. Newcomer, M.D.; Antony D. Loebel, M.D.; Peter Weiden, M.D.; Lewis Warrington, M.D.; Eric Watsky, M.D.; Cynthia Siu, Ph.D.

SUMMARY:

Method: The study included two treatment periods: (i) a 40-week, randomized, double-blind phase comparing ziprasidone (ZIP 80–160 mg/d given BID, N=227; ZIP 80–120 mg/d given QD, N=221) versus haloperidol (HAL 5–20 mg/d, N=151), followed by (ii) a 3-year, double-blind extension phase on the same double-blind medications (ZIP BID N=72, ZIP QD N=67, and HAL N=47, respectively). Logistic regression and Generalized Estimating Equation longitudinal methods were used with adjustments for the effects of dropout.

Results: In the randomized, double-blind, 40-week core study, ziprasidone was associated with greater improvement in efficacy and QLS outcomes than haloperidol, but the differences were not statistically significant. Outcomes observed in the extension phase indicated differential treatment effects favoring ziprasidone (80–160mg/d given BID) compared with haloperidol ($p<0.05$ for PANSS negative, GAF scores and QLS). A similar pattern was observed for the ziprasidone QD group (80–120 mg/d given QD, vs. haloperidol), but differences were not statistically significant.

Conclusions: These results demonstrate the potential for enhanced long-term outcomes in using a second-generation antipsychotic.

REFERENCES:

1. Heinrichs DW, Hanlon TE, Carpenter WT: The quality of life scale: An instrument for rating the schizophrenic deficit syndrome. Schizophr Bull. 1984; 10:388–398.
2. Loebel A, Warington L, Siu C, Lieberman L. Remission in schizophrenia: a comparison of 2 dope regimens of ziprasidone versus haloperidol treatment in a 3-year double-blind extension study.

Poster 38 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

A PUBLIC/PRIVATE PARTNERSHIP IN PROVIDING ACUTE PSYCHIATRIC SERVICES IN A HOSPITAL EMERGENCY DEPARTMENT

Steven Dettwyler, Ph.D., *Director, Community Mental Health, Delaware Division of Substance Abuse and Mental Health, 1901 N. Dupont Highway, New Castle, DE 19720*; Gerard Gallucci, M.D.

SUMMARY:

Delaware's hospital emergency departments (ED) have historically been the entry point for inpatient psychiatric care. Individuals experiencing acute psychiatric crises either present at, or are brought to the ED for treatment. Due to overcrowding, competing priorities and a lack of access to community-based programs, many individuals seen at the ED have been involuntary committed to inpatient psychiatric hospitals often times inappropriately. Through a public/private partnership between the Delaware Division of Substance Abuse and Mental Health (DSAMH) and the Christiana Healthcare System, Delaware has developed an emergency department-based, psychiatric services program that provides space, time and personnel to adequately evaluate an individual as to their need for inpatient or community-based services. The primary goal is to ensure that individuals receive the services they need rather than the services that are most expeditious to the ED resources.

The benefits of this program include the following: First, the ED staff is allowed time and resources to fully evaluate a patient, a process often undermined in the traditional emergency department setting. Second, the staffing of the program includes DSAMH crisis staff that is very familiar with the various community resources and can link individuals to the most appropriate service in a more timely and efficient manner. Finally, connecting to appropriate resources has led to a decrease in inpatient hospitalizations and has reduced the use of the emergency department visits.

REFERENCES:

1. Allen, M.H., Level 1 Psychiatric Emergency Services.The tools of the crisis sector. Psychiatr Clin North Am. 1999 Dec;22(4):713–34, vii.
2. O'Neal TP, Moir R, D'Eramo D. Public, private partners develop emergency psychiatric unit. Health Prog. 1986 May;67(4):65–7.

Poster 39 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

A REVIEW OF 4,188 RECORDS OF MEDICAL EVALUATION AND TREATMENT OF EVACUEES AT RED CROSS SHELTERS IN SHREVEPORT, LOUSIANA IN THE FIRST MONTH FOLLOWING HURRICANE KATRINA

Mary Jo Fitz-Gerald, M.D., *Department of Psychiatry, Louisiana State University Health Sciences Center, 1501 Kings Highway, Shreveport, LA 71130-3932*; Secrest Sutherland

SUMMARY:

Investigators reviewed all available records collected at all three American Red Cross Emergency Shelters in Shreveport, LA in the first month following Hurricane Katrina. Each of the 4,188 records kept in the files of all three Red Cross shelters were collected at the primary site in Shreveport, Louisiana. Of these 4,188 records, those with psychiatric chief complaints, those prescribed psychiatric medications, or those taking or requesting commonly abused prescription medications were analyzed further. Results showed that only ten new cases of acute stress disorder, plus one case of acute stress in a patient with a prior history of depression were diagnosed in those 4,188 patient encounters. However, there were eleven others diagnosed with new onset psychiatric symptoms. This is in contrast to prior reports that showed a large percentage of acute stress disorder symptoms in evacuees in the Houston area (1,2). Shelter location may have influenced the shelter populations. Another possibility is that the evacuee or treatment provider did not recognize or acknowledge acute stress disorder symptoms. This review provides a preliminary assessment of psychiatric needs assessment at shelter locations after natural disasters and provides an area for education and research interventions in the future.

REFERENCES:

1. Spicer SS: Hurricane Katrina: A physician's whirlwind course in disaster psychiatry. J Clin Psychiatry 2005; 66 (11): 1349–50.
2. Coker AL, Hanks JS, Eggleston KS, Risser J, Tee PG, Chronister KJ, Troisi CL, Arafat R, Franzini: Social and mental health needs assessment of Katrina evacuees. Disaster Manag Response; 2006; 4(3): 88–94.

Poster 40 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

APPLYING PRINCIPLES OF ADVANCED CLINICAL ACCESS TO A VETERANS AFFAIRS MEDICAL CENTER MENTAL HEALTH SERVICE LINE

Cheryl W. Jones, M.D., *Department of Veterans Affairs, VAMC, 1201 Broad Rock Boulevard, #116, Richmond, VA 23249*; Antony Fernandez, M.D.; Mark Williams; Joy Barnes, B.A.

SUMMARY:

Background: Advanced Clinical Access (ACA) is a patient-centered, scientifically-based set of redesign principles and tools that enable staff to examine their health care processes and redesign them. The ACA principles result in improved access; improved patient, staff, and provider satisfaction; improved quality; improved efficiency; and decreased cost. ACA's goal is to have no waits or delays and to create appointments that meet the patient's needs in order to provide quality care when veterans want and need it.

Methods: This was accomplished by the strategies that reduced demand for management of uncomplicated first episode depression/anxiety and increase access for complex cases. We redesigned the MHSL Consult template to reflect the Service Line Agreement and services available. We created Same Day Access by the formation of the Urgent Care Clinic. This resulted in decreased external demand for referrals to the system by screening of initial consultations. This enabled us to provide Same Day Access in Clinics within the profiles of providers. We further started Intake Clinics to provide access for new referrals.

Results: The McGuire ACA team redesigned the system of consultation and delivery from the top down. The revised Service Line Agreement ensured treatment

of first episode depression and anxiety by Primary Care, thereby decreasing external demand and creating access for referral of complex cases to the MHSL. The revised Consult Template enables providers to center in on the specific requests and thus decrease external demand. The Urgent Care Clinic and Same Day Access Clinics are tailored to the needs of patients in crisis. New patients scheduled in Intake clinics can be evaluated by a multidisciplinary team reducing individual physician workload while increasing access for new patients. Overall patient satisfaction is improved. The MHSL has instituted Quick cards from August 2006 to May 2007 to solicit feedback from patients regarding their experience with individual providers and/or programs within the MHSL. Of 472 responses 80% of the respondents rated the service delivery as very good to excellent. Our systems-based interdisciplinary model emphasizes and enables liaison and collaboration with other services to provide holistic care to the veterans making movement between services as seamless as possible by breaking down barriers to access wherever possible. Continuous forecasting and contingency planning is essential to the continued balancing of supply and demand.

REFERENCES:

1. Title 38 United States Code (U.S.C.) Sections 1710 and 1705.
2. Code of Federal Regulations, § 17.100, 17.36, 17.37, 17.38, and 17.49.

Poster 41 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PSYCHIATRIC CONSULTATION AT THE FREE MEDICAL CLINIC OF GREATER CLEVELAND: A MODEL FOR IMPROVING ACCESS TO QUALITY MENTAL HEALTH CARE FOR LOW INCOME AND MINORITY PATIENTS

Vikram Kambampati, M.D., *Resident, Department of Psychiatry, Case Western Reserve University Hospitals, 11100 Euclid, Cleveland, OH 44106*; Michael C. Carlisle, D.O.; Kuldeep Vaghela, M.D.; Mathew Vrable, M.D.; Andrea G. Stolar, M.D.

SUMMARY:

Introduction: Primary care is the only source of mental health treatment for many. [1] Collaboration between primary care and mental health specialists is effective in improving clinical outcomes for mental illnesses in managed care. [2] A psychopharmacology consultation clinic was started at the Free Medical Clinic of Greater Cleveland, which provides primary care to the indigent. We hypothesized that collaborative care improves mental health outcomes for low income and minority patients, and aimed to develop a model that can be replicated.

Method: Demographic data of patients during 6 months of the last year was provided by the Free Clinic. We also performed a literature review to identify controlled trials involving collaborative care for mental illness and a significant proportion of minorities or low income patients.

Results: 70% of Free Clinic patients were African-American, 84% lived in poverty, and 90% lacked any insurance. Although few studies involved significant proportions of low-income or minority patients, a small number demonstrated varying interventions and outcomes. In general, collaboration improved clinical outcomes, but increased direct costs. A model of collaborative care based on this data is presented.

Importance: At the end of this presentation, participants will learn that collaborative care for mental illness is effective and feasible.

REFERENCES:

1. Wang PS, et.al: Twelve-month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Republication. Arch Gen Psychiatry 2005; 62:629–640.
2. Gilbody S, et.al.: Collaborative Care for Depression. A Cumulative Meta-analysis and Review of Longer-term Outcomes. Arch Intern Med 2006; 6:2314–2321.

Poster 42 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

ELECTRONIC INPATIENT TREATMENT PLANS: OPTIMIZING THE PROCESS

Simon Kung, M.D., *1966 Fox Valley Drive S.W., Rochester, MN 55902-3440*; Maria I. Lapid, M.D.; Timothy W. Lineberry, M.D.

SUMMARY:

Introduction: Inpatient treatment plans serve many purposes, including patient care and regulatory/ accreditation requirements. With shorter length-of-stays and complex problems, documentation on paper impedes efficiency. We describe an in-house, computerized treatment plan developed to improve the treatment planning process.

Methods: We implemented a web-based computer application to replace the previously used paper treatment plans. After one year of use, we surveyed our staff regarding time savings, satisfaction, and benefits of the electronic treatment plan.

Results: A total of 103 (37%) out of 282 physicians, nurses, and allied health staff members responded to the

survey. In starting a new treatment plan, an average time savings of 4.8 minutes (12.6 for paper, 7.8 for computer) was seen. In updating an existing treatment plan, an average time savings of 3.0 minutes (7.1 for paper, 4.1 minutes for computer) was seen. Overall staff satisfaction increased by 44%, from 38% to 82%. Benefits of an electronic treatment plan include time and productivity savings, ease of accessibility and sharing, improved compliance of use, and more integrated multidisciplinary interactions.

Conclusion: A user-friendly, computerized treatment plan can make the inpatient treatment plan a useful document for patient care and improve provider satisfaction, in addition to meeting regulatory/accreditation requirements.

REFERENCES:

1. Kennedy JA. Fundamentals of Psychiatric Treatment Planning. 2nd Ed. Washington, DC: American Psychiatric Publishing, Inc; 2003.
2. Johnson DW, Johnson SJ. Real World Treatment Planning. Pacific Grove, CA: Brooks/Cole-Thomson Learning; 2003.

Poster 43 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

CAN THE PATIENT HEALTH QUESTIONNAIRE REPLACE THE BECK DEPRESSION INVENTORY FOR INPATIENT DEPRESSION MEASUREMENT?

Simon Kung, M.D., *1966 Fox Valley Drive S.W., Rochester, MN 55902-3440*; Vicki Courson, M.S.; Susanna Stevens, M.S.; Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

Objective: This study evaluated the correlation and agreement between the BDI-II (Beck Depression Inventory) and PHQ-9 (Patient Health Questionnaire) depression self-assessment instruments on an inpatient depression unit.

Methods: We conducted a retrospective study on hospitalized depressed patients who completed a BDI-II and PHQ-9 on admission and discharge as part of routine clinical assessment. Correlations between the BDI-II and PHQ-9 for admission, discharge, and combined data were calculated. Individual item comparison was performed using matched pair analysis with correlations and weighted Kappas.

Results: 129 patients representing 141 hospital admissions were included. Median length of stay was 7 days. Mean BDI-II scores on admission and discharge were 34.6 and 14. Median PHQ-9 scores on admission and discharge were 18.8 and 8.2. Correlations between total BDI-II and PHQ-9 scores were 0.72 for admission, 0.77 for discharge, and 0.86 for both. Matched pair analysis for individual PHQ items compared to its corresponding BDI-II item(s) showed small mean differences of less than 0.5. However, only 6 results were statistically similar. Individual item correlations were mostly less than 0.7. Weighted Kappa coefficients were mostly in the fair to moderate agreement category.

Conclusions: The total BDI-II and PHQ-9 scores showed good correlation, suggesting that for a global measure of depressive symptoms over a short inpatient stay, the PHQ-9 can reasonably substitute for the BDI-II. However, individual item correlation and strength of agreement were less, indicating that direct item comparison is mostly not valid. No external funding sources.

REFERENCES:

1. Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals 2002; 32:509–521.
2. Beck, AT, Steer RA. Internal consistencies of the original and revised Beck Depression Inventory. J Clinical Psychology 1984; 40:1365–7.

Poster 44 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

THE PREVALENCE OF OSTEOPOROSIS IN PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Matthew Macaluso, D.O., *Resident, Department of Psychiatry, University of Medicine and Dentistry of New Jersey, 671 Hoes Lane Room C-205, Piscataway, NJ 08854*; Anthony M. Tobia, M.D.; Raj Singh, M.D.; Cheryl Graber, M.D.

SUMMARY:

Objective: To study the prevalence of osteoporosis risk factors in patients with severe and persistent mental illness (SPMI) attending a partial hospital (PH) program, and investigate the relationship between risk factors and the prevalence of osteoporosis in this population.

Methods: A chart review was performed on subjects with severe and persistent mental illness at the UMDNJ-UBHC Monmouth Junction Extended-Partial hospital. Risk factors for osteoporosis were assessed, and screening bone densitometry will be performed for those deemed at risk per current guidelines. There are 30 at-risk patients involved in this pilot study, aged between 40 and 60 years old. The DEXA scans will be performed at the Osteoporosis Center, Robert Wood Johnson Medical School.

Results: Results on 18 of 30 patients indicate a high incidence of risk factors for osteoporosis in our SPMI population. Non-modifiable risk factors included gender, age, ethnicity, family history, and personal history of fracture or tooth loss. There was also a high prevalence of modifiable risk factors including hypogonadism, thyroid disease, inadequate calcium and vitamin intake, sedentary life style, cigarette smoking, and co-occurring medical conditions that predispose to osteoporosis. Approximately 45% of patients screened had viral hepatitis, and 28% were found to be on anticonvulsant medication.

Conclusions: Medical comorbidity plays a significant role in the early mortality and morbidity in the SPMI population. Osteoporosis and subsequent fracture contribute to these findings. Our study revealed an increased prevalence of risk factors predisposing to SPMI patients to osteoporosis. Correlating these findings with DEXA scan results will enable clinicians to develop strategies to reduce the risk of osteoporosis in this population.

REFERENCES:

1. Hummer M, Malik P, Gasser RW, et.al: Osteoporosis in patients with schizophrenia. Am J Psychiatry 2005;2(1):2–7.
2. Wyszogrodzka-Kucharska A, Rabe-Jablonska J: Decrease in mineral bone density in schizophrenic patients treated with 2nd generation antipsychotics. Psychiatria Polska 2005; 39(6):1173–84.

Poster 45 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PREMATURE PATIENT DISCHARGE IN THE EMERGENCY SETTING

Hindi Mermelstein, M.D., *Medical Director, Adult Ambulatory Clinic, Zucker Hillside Hospital; and Department of Psychiatry, North Shore University Hospital, 91 Bayview Avenue, Great Neck, NY 11021-1033*

SUMMARY:

Objectives: Mental disorders are prevalent, costly and inherently risky to self and others. Emergency rooms (ER) often serve as therapeutic entry point. Many individuals leave before the assessment is complete. To date, there have been few reports focusing on these patients. We sought to determine the impact of psychiatric illness and other factors on premature patient prompted discharge in the ER. By doing so, we hope to develop strategies to lessen premature leave-taking and enable us to provide the care needed.

Methods: We conducted a retrospective, consecutive chart review of the approximately 300,000 ER visits to a university-affiliated hospital between 1/1/2002 and 7/30/2006. Medical, demographic and other factors were collected and the rates of premature elopement in the psychiatric and non-psychiatric groups were compared using a chi-squared test.

Results: Psychiatric complaints more than doubled the rate of premature discharge (2.4% vs. 1.0%, $p<0.01$) with anxiety symptoms found most frequently. Worrisome is the 10% rate of suicidal ideation, parasuicidal behaviors and actual attempts among those who left.

Conclusion: Psychiatric distress, doubles the rate for premature patient prompted discharge. Further study is needed as we believe these individuals represent a highly distressed and symptomatic group at risk for an uncertain and even dangerous outcome.

REFERENCES:

1. Arendt et.al. The Left-Without-Being-Seen Patients: What would keep them from leaving? Ann Emerg Med. 2003:42(3):317–23.
2. Miro et.al. More data about patients who leave the emergency department without being seen by a doctor in European hospitals. European Journal of Emergency Medicine, 2000:7:79–80.

Poster 46 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PORTABLE TELEMEDICINE AND MOVEMENT DISORDER EVALUATION

Jose E. Nieves, M.D., *Department of Psychiatry, Veterans Administration/Eastern Virginia Medical School, 203 Fairfield Drive, Yorktown, VA 23692*

SUMMARY:

We have successfully deployed videophones in our psychiatric intensive case management (1) program to increase access to medical psychiatric care to 60 seriously mentally ill patients. The catchment area covers about 20,000 miles, surrounding the Chesapeake Bay, with multiple geographic and functional barriers such as bridges and tunnels frequently subject to severe traffic congestions. In addition, most of our patients have medical comorbidities that make travel uncomfortable. Videophones are a telehealth alternative uniquely tailored for this use because of their durability, portability, (less than 1 lb.) and ease of use.Videophones have been employed to provide medication management, caretaker discussions and pharmacy consultations. Recently, videophones have been used for evaluating abnormal involuntary movements. Telehealth applications in movement disorders have been limited, but used successfully in some instances of Parkinsons Disease (2). Videophones in particular have long been considered of limited use in movement disorders and subtle negative psychiatric symptoms such as affect because of their limited bandwidth and resolution. Our experience is that videophones can be used successfully in most instances other than

small amplitude tremors e.g., the face, and provide an alternative for the evaluation of high amplitude tremors and moderate to severe dyskinetic movements.

REFERENCES:

1. Nieves J.E. Videophones and Psychiatry, Clinical Psychiatric News, March 2006, Vol. 34,#3, page 22.
2. Samii, A, Ryan-Dykes, P.; Tsukuda,R.A.; Tele-medicine for Delivery of Health Care in Parkinson's Disease, Journal of Telemedicine and Telecare, 2006 Vol. 12,#1 pages 6–18.

Poster 47 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

IMPACT OF FORMULARY CHANGES IN ANTIDEPRESSANT TREATMENT IN ELDERLY NURSING HOME PATIENTS

Supported by Forest Research Institute

M. Haim Erder, Ph.D., *Executive Director, Health Economics, Forest Research Institute, Harborside Financial Center, Plaza V, Jersey City, NJ 07311*; Moshe Fridman, Ph.D.

SUMMARY:

Objectives: To evaluate the impact of switching antidepressant (AD) drugs due to formulary policy in elderly nursing home (NH) patients.

Methods: A retrospective chart review of patients who received escitalopram for at least 30 days was conducted by an independent contractor (Omnicare); follow-up comprised the next consecutive 60 days. The no-switch (NSW) group received escitalopram for 90 days; the switch (SW) group was switched to another SSRI due to formulary policy. Data on comorbidities, behavior problems, symptoms, and resource use were compared.

Results: 417 charts were reviewed (NSW=251; SW=6). In the SW group, 63% were switched to citalopram. Worsening = 2 symptoms and/or behaviors was observed in 41% vs. 15% (P=0.001) in the SW group compared to the NSW group. Two behavior problem factors characterizing abusive behavior and repetitive complaints (P<0.05) and two symptom factors characterizing abdominal symptoms and aches/anxiety/fatigue (P<0.05) were significantly worse for the SW group. The SW group experienced significant reduction in weight and increase in use of drugs.

Discussion: The analyses are indicative of an increase in certain behavioral problems and symptoms in elderly NH patients switching AD drugs due to formulary decisions; a larger sample size is required to confirm these findings.

REFERENCES:

1. Melartin TK:Continuity is the main challenge in treating major depressive disorder in psychiatric care. J Clin Psychiatry 2005;66:220–227.
2. Moore N. Prospective, multicenter, randomized, double-blind study of the efficacy of escitalopram versus citalopram in outpatient treatment of major depressive disorder. Int. Clinical Psychopharmacology 2005;20:131–137.

Poster 48 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

A STATE-BY-STATE COMPARISON OF EXCLUSIONS TO INVOLUNTARY COMMITMENT LAWS

Claire L. Pouncey, M.D., Ph.D., *Staff Psychiatrist, Department of Psychiatry, Belmont Center for Comprehensive Treatment, 3600 Conshohocken Avenue, Apt. 113, Philadelphia, PA 19131-5302*; Karolyn Adler, Esq.; Lawrence A. Real, M.D.; Fayez El Gabalawi, M.D.

SUMMARY:

This poster summarizes an ongoing debate among participants in the Philadelphia mental health court system about the relevance of the Pennsylvania Mental Health Procedures Act of 1976 (MHPA) as contemporary medical understanding of mental illness evolves. The MHPA protects persons with mental illness from civil liberties abuses by the government and the mental health care system, by specifying the circumstances under which a person may be committed for inpatient psychiatric treatment. The MHPA contains three specific exclusions from involuntary commitment: persons with "senility", "mental retardation", or "drug and alcohol dependence" may not be involuntarily committed to a psychiatric facility. Persons with mental retardation may be committed under a different statute, but without the due process protections afforded the individual under the MHPA. State law mandates that the language of a statute be strictly interpreted by the courts. This requirement preserves the moral intent of the legislation, but it creates problems for court officers. Whereas the MHPA is grounded in the language of DSM-II, psychiatric nosology and theory have progressed to more detailed and subtle thinking about the relationships between the so-called "organic" conditions that preclude involuntary commitment, and the psychiatric morbidities and behavioral disturbances with which they often co-occur. Court officers, who adjudicate the commitment hearings, and the psychiatrists who testify at them, often experience a tension between the desire to promote the legislative intent and the clinical realities that intrude at the level of individual cases. In this poster, we look to other

states for guidance about which conditions to exclude from involuntary commitment, and the theoretical bases for these exclusions. We find that states' exclusions to involuntary commitment vary enormously. The poster compares the various states' exclusions in order to identify themes among them regarding historical, moral, political, and theoretical considerations that shape statutory language. We use these data to suggest model language and theoretical justifications that could be used to maximize interstate legislative uniformity, and to provide flexibility so that psychiatric theory does not outpace the state laws that govern involuntary psychiatric commitment.

REFERENCES:

1. Pennsylvania Mental Health and Mental Retardation Act, 50 Pa. Stat. Ann. tit. 50, § 7101–7503 (West 2001).
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Second Edition. Washington, DC, American Psychiatric Association, 1968.

Poster 49 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

HOUSE CALL TO THE HOMELESS: THE ROLE OF THE PPOH ON-SITE PSYCHIATRIST IN A DROP-IN CENTER

Gertie D. Quitangon, M.D., *Staff Psychiatrist, Center for Urban Community Services, Inc., 74 Trinity Place, Suite 800, New York, NY 10006*; Dinarra M. Amanbekova, M.D.; Sermet Demir, R.N.; Fiona Mason, M.S.W.; Vera Osipyan, M.S.W.

SUMMARY:

Introduction: The mission to end homelessness has been receiving attention from every level of government. In New York City, the Mayor set the goal of reducing shelter and street homelessness by two-thirds in five years. The purpose of this study is to demonstrate that providing psychiatric services on-site in a drop-in center is effective in expediting housing placement and facilitating psychiatric treatment of the homeless.

Method: Charts (N =65) were reviewed at a drop-in center in New York City. Clients discharged from July to December 2006 were assigned to Group 1 (N = 32] if they were seen by a PPOH on-site psychiatrist and to Group 2 (N =33) if they were not. Medication compliance, hospitalization rate, length of stay at the drop-in center and number of housing placements were compared.

Results: Clients seen by the PPOH on-site psychiatrist had higher rates of medication compliance and housing placement and stayed an average of six months. There was no difference in hospitalization rate between groups.

Conclusion: Given that sixty percent of the homeless have mental illness, future research should focus on the impact of an on-site psychiatrist in drop-in centers in providing appropriate care and expediting housing placement.

REFERENCES:

1. Rosenheck RA, Resnick SG, Morrissey JP: Closing service system gaps for homeless clients with dual diagnosis: integrated teams and interagency cooperation. J Mental Health Policy Econ.2003 June; 6(2):77–87.
2. Rosenheck R, et.al: Service delivery and community: social capital, service systems integration, and outcomes among homeless persons with severe mental illness. Health Serv Res. 2001 Aug; 36(4): 691–710.

Poster 50 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

COMPARING THE DYNAMICS AND PROCESSES IN SPIRITUAL GROUPS AND PSYCHOTHERAPY GROUPS: UNDERSTANDING THE SPIRITUALITY-PSYCHIATRY INTERPHASE

Parameshwaran Ramakrishnan, M.D., *Research Fellow, HELP Foundation, Park Plaza Clinic, Affiliated With Creighton University, 105 N. 31st Avenue, Suite 102, Omaha, NE 68131*; Sriram Ramaswamy, M.D., *Assistant Professor, Department of Psychiatry, Creighton University, 3528 Dodge Street, Omaha, NE 68131-3202*; Jon Kayne, Ph.D.; Subhash C. Bhatia, M.D.

SUMMARY:

Background: Up until the last century psychiatrists have alienated all spiritual beliefs and practices as demonical and pathological however 21st century has brought in a spiritual renaissance into this field. On the other hand religious/spiritual organizations have been caring for the distressed and mentally ill patients since times immemorial. Though both these groups care for improving the general level of happiness in the society they have been functioning indepedently.

Aim: With this study we aim (1) to understand the dynamics and processes in spiritual groups and (2) to compare the spiritual and psychotherapeutic techniques with the objective to tie the loose ends of psychiatry and spirituality and to educate the early career psychiatrist.

Method: A brief review is given of the history of transition from initial alienation to the present spiritual renaissance in the mental health profession. Reference is then made to spiritual practices in various religious

groups of the world with an attempt to understand their group dynamics and processes. Various spiritual techniques and principles are described here with in comparison to the traditional psychotherapeutic practices.

Results and Conclusion: There has been a growing interest among the psychiatrists to provide for the spiritual needs of the patients leading to a number of studies related to assessment of spiritual needs and interventions in specific diagnostic groups in mental health. This has also lead to introduction of spiritual topics into the curriculum of residency programs and start of Spiritual – psychiatry interest group under American Psychiatric Association. However, there has been no scientific study on the functioning of the spiritual organizations with a mental health perspective. With the common goal of improving the level of happiness in the society, early career psychiatrists have to work towards this interphase of psychiatry and spirituality.

REFERENCES:

1. Baetz M, Griffin R, Bowen R, Marcoux G. Spirituality and psychiatry in Canada: psychiatric practice compared with patient expectations. Canadian Journal of Psychiatry. 2004 Apr; 49(4):265–71.
2. Hayward R. Demonology, neurology, and medicine in Edwardian Britain. Bulletin of the History of Medicine. 2004 Spring; 78(1):37–58.

Poster 51 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

HANDLING VIOLENT AND AGGRESSIVE PATIENTS: REVISITING PHYSICAL/ RESTRAINT METHODS IN PSYCHIATRIC PRACTICE

Parameshwaran Ramakrishnan, M.D., *Research Fellow, HELP Foundation, Park Plaza Clinic, Affiliated With Creighton University, 105 N. 31st Avenue, Suite 102, Omaha, NE 68131*; Lorraine Vanega, R.N.; Sriram Ramaswamy, M.D.; Subhash C. Bhatia, M.D.

SUMMARY:

Background: While institutions and clinicians strive to promote restraint-free environment of care, there are some patients, such as those with severely agitated manic or psychotic episodes, who may require aggressive therapeutic interventions including physical restraints for behavioral control to prevent danger to self or others.

Aim: To study methods for physical restraint and precautions needed regarding its use.

Method: A literature search was conducted to identify publications on physical restraint practices. Common forms of restraint employed were knotted sheets or padded belts and bands. We compared the methods used in older versus contemporary psychiatric practice settings.

Result: Literature describes the value of staff training in predicting violent behavior, diffusing aggressive behaviors and when to use or not to use restraints. The importance of physical restraint lies primarily in preventing injury to patient, staff and to prevent disruption of therapeutic milieu. Restraint may therefore be useful in the management of agitated and aggressive patients not well controlled by medications.

Conclusion: Notwithstanding general public opinion, physical restraint may have its place in emergency medical and psychiatric care. We discuss this and consider measures of and guidelines for physical restraint methods for behavioral control. We will also share photographs of various physical restraint types.

REFERENCES:

1. Fisher W A (1994) Restraint and seclusion: a review of the literature. American Journal of Psychiatry, 151:1584–1591.
2. Goswami U. (2003) Practice of Physical Retraint and seclusion in India: A call for consensus. Indian Journal of Psychiatry, 45 (1), 1–2.

Poster 52 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

CRIMINAL HISTORY AND ITS RELATION TO FEMALE INPATIENT VIOLENCE

Nicole A. Reid, M.D., *Instructor, Department of Psychiatry, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461*; Ali Khadivi, Ph.D.; Merrill R. Rotter, M.D

SUMMARY:

Criminal history is associated with inpatient violence in males. However, less is known about the relationship of criminal history to inpatient violence in females. The purpose of the study was to examine the prevalence of criminal history in female civil psychiatric inpatients and its relation to inpatient violence.

Methods: A retrospective chart review was conducted on the medical records of all consecutively admitted female psychiatric patients (N=97) from 2005 to 2007. The criminal history was independently obtained from patient's past criminal records. The inpatient violence was defined as any event where there was unwanted physical contact with intent to harm person or property. The sample (N=97) was predominately African-American (45%), and Latino (41%); with a mean age of 40. Sixty- two percent of the sample had diagnosis of Schizoaffective or Schizophrenia.

Results: Seventy-two percent (n=70) of the sample had past criminal history, which included multiple vio-

lent crimes and felony charges. There were 138 violent incidents during the study periods. Patients with criminal history accounted for slightly more than half (51%) of total violent episodes. Patients without history of criminal behavior were equally violent and accounted for 48% of total violence. Only 26% of patient with criminal history became violent. In contrast, 74% of patients without criminal history were violent.

Conclusion: There is high prevalence of criminal behavior in female psychiatric inpatients; however, patients without criminal records were more violent.

REFERENCES:

1. Repetitively Assaultive Psychiatric Patients: Review of Published Findings, Raymond B. Flannery, Jr., Ph.D., Psychiatric Quarterly, Vol. 73, No. 3, Fall 2002.
2. Documentation of Violence Risk Information in Psychiatric Hospital Patient Charts: An Empirical Examination, Eric B. Elbogen, Ph.D., et.al, Journal of the American Academy of Psychiatry and the Law 31:58–64, 2003.

Poster 53 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

FACTORS AFFECTING LENGTH OF STAY ON AN INPATIENT PSYCHIATRIC UNIT

Matthew R. Schneider, M.D., *Attending Psychiatrist, Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Klau 2, Bronx, NY 10467*

SUMMARY:

Objective: Length of stay on psychiatric inpatient units is a significant clinical and economic issue. This poster examines various factors and their effect on length of stay.

Method: All discharges for six months from the caseload of 1 full-time psychiatrist on a general psychiatric inpatient unit were examined to tabulate data regarding length of stay. Individual factors analyzed included gender, race, age, referral source, housing status, preexisting care, insurance coverage, diagnosis, significant Axis III condition, presenting suicide attempt, legal status and language spoken.

Results: 154 patient were included in the study. The overall average length of stay was 11.32 days. Factors contributing significantly to a lengthening of stay included: age over 60 years old, homelessness, non-managed medicare insurance, diagnosis of mania and involuntary committment. Factors contributing significantly to a reduced length of stay included: Hispanic or Asian ethnicity, age between 13 and 17 years of age, private health care insurance, diagnosis of depression or primary Axis II disorder and voluntary legal status.

Conclusion: Many factors affect length of stay on an inpatient psychiatric unit, only a few of which are clinically based. Demographic and socio-economic factors contribute significantly to length of stay.

REFERENCES:

1. Blais MA: Development and application of a brief multi-faceted tool for evaluating inpatient psychiatric care. Adm Policy Ment Health 2002; 30: 159–172.
2. Bobo WV: Characteristics of repeat users of an inpatient psychiatry service at a large military tertiary care hospital. Military Medicine 2004; 9: 648–653.

Poster 54 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PATIENTS' DILEMMA: MEDICATION OR THERAPY

Chandresh Shah, M.D., *Associate Clinical Professor of Psychiatry, Department of Psychiatry, University of Southern California, 350 E. Temple Street, Los Angeles, CA 90012*

SUMMARY:

Patients requesting mental health (MH) treatment have personal perspective regarding their illness and cure. MH providers also have professional perspective regarding diagnosis and treatment. Mismatch between these perspectives may lead to non-acceptance or poor adherence to treatment. Patients requesting MH evaluation in an ambulatory care center over a period of 6 months were followed for 12 months. Out of 200 patients, 176 patients (age=53.99+13.28 years) were recommended for either psychotherapy (TX) or pharmacotherapy (RX) or both. These patients were followed for acceptance or rejection of recommended treatment, and adherence to it. There were 85.72% of patients (age=54.01+12.91 years) who accepted RX, in contrast to only 41.67% of patients (age=55.05+13. years) who accepted TX ($p<0.005$). Those patients accepting treatment showed greater adherence ($p<0.05$) to RX (276.17+129.86 days) in comparison to TX (181.90+150.18 days). In each group, those who accepted treatment were older in age, the difference being non-significant. These data show that patients themselves have certain desires and expectations for their treatment need. MH evaluation, treatment recommendations and resource allocation should consider these patient perspectives.

REFERENCES:

1. Edlund MJ, Wang PS, Berglund PA, et.al: Dropping out of mental health treatment – patterns and predictors among epidemiological survey respondents

in the United States and Ontario. Am J Psychiatry. 2002 May;159(5):845–51.
2. Killapsy H, Benerjee S, King M, Lloyd M: Prospective controlled study of psychiatric outpatient non-attendance. Characteristics and outcome. Br J Psychiatry. 2000 Feb;176:0–5.

Poster 55 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

THE DEPARTED: TEEN HOMICIDE AND SUICIDE IN BOSTON, A 15-YEAR REVIEW

Akhil Shenoy, M.D., *Clinical Instructor in Psychiatry, Department of Psychiatry, Boston University, 740 Albany Street, Dowling 7 South, Boston, MA 02118*; Dan J. Siskind, M.D., M.P.H.

SUMMARY:

Background: In the 1990's there was a rise of adolescent homicides and suicides in Boston. Homicides peaked around 1993–1994. Suicide rates were also on the rise; this culminated in a contagion of completed and attempted adolescent suicides during the summer of 1997 in South Boston. Community programs and services to address homicide and mental health problems including substance abuse were introduced in the mid-1990's.

Aims: This poster aims to review trends in homicide, violence, suicide, and suicide behavior among adolescents in Boston over the past fifteen years. We will attempt to ascertain the existence of a correlation between suicide and homicide in Boston and to ascertain the roles in which community programs have had in lowering the rates. We will also review other risk factors such as substance abuse rates, poverty, and education as correlates of homicidal and suicidal behavior.

Methods: We used data from the Massachusetts Vital Statistics for Suicide Rates, the FBI's Supplementary Homicide Reports on homicide, the Unified Hospital Discharge Data Set on self harm and the Youth Risk Behavior Survey for violent behavior and other behavioral risk factors. We compared this data to look for trends and correlations using linear regression in EPI info.

Results: The rates of homicide peaked in the early 1990's and again in 2005. These increases in rate correlated with violent behavior. Suicide rates among adolescents increased in the mid-1990's before decreasing at the end of the century and appears to be rising in recent years. Rates in suicidal ideation and behavior appear to follow these trends. Although there appears to be a correlation between homicide and suicide, it does not reach statistical significance.

Conclusions: There are possible correlates between homicide and suicide. This relationship may be evident in our study of Boston trends over the 1990–2005 period. It is possible that the increase in public programs to address suicide and homicide, a dividend of the strong state economy, and strict gun control laws helped keep Massachusetts below the national average and offset the effects of the rise of substance abuse.

REFERENCES:

1. ''Explaining the Rise in Youth Suicide'', David Cutler et.al, Working Paper 7713 (http://www.nber.org/papers/w7113), National Bureau of Economic Research, Cambridge, MA, May 2000.
2. Youth risk behavior surveillance—United States, 2005, Eaton DK et.al, MMWR Surveill Summ. 2006 Jun 9;55(5):1–108.

Poster 56 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

PREVALENCE AND IMPACT OF PSYCHIATRIC MORBIDITY AND STRESS REACTIVITY IN PATIENTS WITH PSORIASIS: A CROSS SECTIONAL SURVEY OF DERMATOLOGY OUTPATIENTS

Senthil A. Subramanian, M.D., *Resident, Department of Psychiatry, Stanley Medical College, Old Jail Road, Chennai, India 60003*; Purushothaman Subramanian, M.D.; Lena K. Palaniyappan

SUMMARY:

Purpose and Content: Prevalence of psychiatric morbidity is higher in psoriasis than many other skin diseases. Stressful life events consistently show an association with disease exacerbation. Depression, suicidal ideation and abnormal stress reactivity are shown to be significantly associated with psoriasis. The study presented here is a cross-sectional survey conducted at a dermatology clinic of a state-owned university hospital in urban south India.

Method and Results: Disease severity, quality of life, disease related stress, depressive symptoms and suicidal ideation were measured using validated tools across the consecutive cross-sectional sample of 150 consenting OPD patients with clinical exacerbation of psoriasis. 30% of sample had depressive features with 5% qualifying for suicidal ideation. Psoriasis related stress and poor quality of life correlated significantly with depression scores on multiple regression analysis. Patients with psoriasis vulgaris tend to have more depression when compared to other types. As psoriasis vulgaris tend to involve more visible areas, the resultant cosmetic disfigurement might have played a role in these patients developing depression.

Implications: Stress reactors tend to have more psychiatric morbidity and more impairment of disease related quality of but stress reactivity and disease severity were not associated significantly. This indicates that stress reactivity is more of a subjective phenomenon and needs targeting while treating psoriasis.

Conclusion: Psychiatric screening, assessment and intervention are imperative in psoriatic patients.

REFERENCES:

1. Akay A, Peckcanlar A, Bozdaga KE. Assessment of depression in subjects with psoriasis vulgaris and lichen planus. J Eur Acad Dermatol Venereal 2002; (4): 347–52.
2. Zachariae R, Oster H, Bjerring P. Effects of psychologic intervention on psoriasis: a preliminary report. J Am Acad Dermatol 1996; 34: 1008–1015.

Poster 57 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

IRONY, IRREVERENCE, AND INSTIGATION: HUMOR BETWEEN PSYCHIATRIC EMERGENCY ROOM STAFF

Andrew W. White, Ph.D., *Project Coordinator, Department of Psychiatry and Behavioral Sciences, Boston University School of Public Health, 715 Albany Street, T246W, Boston, MA 02118*; Cassandra Aldsworth, B.A.; Peggy L. Johnson, M.D.; Lee Strunin, Ph.D.

SUMMARY:

Background: The psychiatric emergency room (PER) plays an important role in the community mental health system, acting as both a triage center and point of entry for individuals in acute psychiatric distress. PER staff have the unique challenge of providing services in an acute setting requiring a great deal of work in an expedited manner. These data are part of a larger study of Staff Perspectives of PER Care.

Methods: Structured observations were conducted in non-clinical staff and public areas of the PER over a 4 month period. Over 70 observation hours were collected across all shifts and days of the week. A coding schema for the social environment focusing on staff activities and PER staff interactions was developed and an iterative coding process was used.

Analysis: Qualitative data analysis identified that humor was an important aspect of PER work. Staff used humor in their interactions with each other to express frustration about patients, bond over system issues, and express affection and camaraderie towards other staff. This poster will present themes related to humor from the observational data. The study provides a unique perspective into the day-to-day lives of staff in the PER.

REFERENCES:

1. van Wormer, K. Boes, M. (1997). Humor in the emergency room: A social work perspective. Health & Social Work, Vol 22(2).
2. Lipson, J. G., Koehler, S. L. (1986). The psychiatric emergency room: Staff subculture. Issues in Mental Health Nursing, Vol 8(3).

Poster 58 **Thursday, October 11 3:00 p.m.-4:30 p.m.**

VALUE OF THE PSYCHIATRIC EMERGENCY SERVICE OVER THE MODEL OF PSYCHIATRIC CONSULTATION TO THE EMERGENCY DEPARTMENT

Benjamin K.P. Woo, M.D., *Resident, Department of Psychiatry, UCLA, 1830 Flower Street, Room 3057, Bakersfield, CA 93305*; Stephanie Kua, B.S.

SUMMARY:

Objective: To evaluate the benefits of the psychiatric emergency service (PES) model, in comparison to the model of the psychiatric consultant to the emergency department (the consultation model).

Methods: A retrospective chart review of 100 involuntary PES patients and 100 involuntary patients of the consultation model were matched for age, sex, ethnicity, and primary diagnosis. Baseline characteristics, demographics, and various outcomes of the two groups were compared.

Results: After establishment of the psychiatric emergency service, there were improvements in the following categories: 1.) Timely rendering of psychiatric emergency care (330 vs. 639 minutes, $p<0.01$); 2.) Completion of mental status exam (95% vs. 49%, $p<0.01$); 3.) Pregnancy testing (73% vs. 52%, $p<0.05$); and 4.) Safety in the form of seclusion (6% vs. 15%, $p<0.05$) and elopement (5% vs. 13%, $p<0.05$). There was no statistical significance in urine toxicology ordered, follow-up care provided, and re-admission rate after 30 days.

Conclusion: The PES is a multidisciplinary system that can be beneficial to psychiatric emergency patients by providing timely rendering of care, improving access to care, and ensuring safety and better assessment.

REFERENCES:

1. Allen MH: Level 1 psychiatric emergency services. Psychiatr Clin North Am 22:713–734, 1999.
2. Woo BK, Sevilla CC, Obrocea GV: Factors influencing the stability of psychiatric diagnoses in the emer-

gency setting: review of 934 consecutive inpatient admissions. General Hospital Psychiatry 28(5):434–436, 2006.

POSTER SESSION 3

Posters 59–87
Friday, October 12

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

BIOLOGICAL PSYCHOLOGY AND PHARMACOLOGY: PART I

Poster 59 **Friday, October 12 8:30 a.m.-10:00 a.m.**

12-MONTH SAFETY AND EFFICACY TRANSDERMAL METHYLPHENIDATE IN CHILDREN WITH ADHD

Oscar G. Bukstein, M.D., M.P.H., *Associate Professor of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; Frank Lopez, M.D.; Robert L. Findling, M.D.; John Turnbow, M.D.; Angela LeDay, Ph.D.

SUMMARY:

Objective: Evaluate the safety and efficacy of methylphenidate transdermal system (MTS) during long-term (up to 12-months) treatment in pediatric subjects with attention-deficit/hyperactivity disorder (ADHD).

Methods: Children (6–12 years) exposed to MTS, placebo, or OROS® MPH in previous MTS trials, entered an open-label, extension study. Subjects already receiving optimized MTS doses continued on this dose for 12 months; those who were not underwent a 4-week MTS stepwise dose-titration to an optimal MTS dose and continued on this dose for 11-months. Safety, including adverse events (AEs) and patch tolerability, was assessed throughout. Clinician (ADHD RS IV, CGI) and parent-rated (PGA) efficacy measures were assessed weekly (Weeks 1–4), monthly (Months 2–6) and every 2 months thereafter.

Results: Most (98%) treatment AEs were mild/moderate; the most common (>10% of subjects) included decreased appetite, headache, upper respiratory tract infection, cough, pyrexia and decreased weight. Three serious AEs were reported and considered unrelated to study treatment. Compared with baseline, MTS reduced ADHD RS IV total scores (P<.0001) and improved CGI and PGA ratings (P<.0001) at endpoint.

Conclusions: Reported AEs included those typical for methylphenidate. Overall, the safety profile was consistent with previous MTS studies and other approved methylphenidate products. MTS demonstrated efficacy with up to 12-months of treatment.

REFERENCES:

1. McGough JJ, Wigal SB, et.al. A randomized, double-blind, placebo-controlled, laboratory classroom assessment of methylphenidate transdermal system in children with ADHD. Journal of Attention Disorders. 2006;9:3:476–485.
2. Anderson VR, Scott LJ. Methylphenidate transdermal system in attention-deficit hyperactivity disorder in children. Drugs. 2006:66(8):1117–1126.

Poster 60 **Friday, October 12 8:30 a.m.-10:00 a.m.**

RETENTION RATES ON RISPERIDONE LONG-ACTING VERSUS ORAL ANTIPSYCHOTICS

Supported by Janssen Cilag, Spain

Annette Lam, M.S., *Manager, Worldwide Health Economics and Pricing, Johnson & Johnson Pharmaceutical Services, 19 Green Belt Drive, Toronto, Ontario, Canada M3C 1LP*; Jose Olivares, M.D.; Alexander Rodriquez Morales; Joris Diels; Zhongyun Zhao, Ph.D.

SUMMARY:

Objective: To assess the difference in treatment discontinuation for patients with schizophrenia treated with Risperidone Long-Acting Injection (RLAI) versus oral antipsychotics enrolled in the electronic Schizophrenia Adherence Registry (e-STAR) in Spain.

Methods: E-STAR, a secure, web-based, international, long-term, prospective, observational study of patients with schizophrenia who commence a new antipsychotic drug during their routine clinical management collects data retrospectively and prospectively.

Results: Of 1,622 patients, 1,345 were initiated on RLAI and 277 on oral antipsychotics at baseline. RLAI treated patients had significantly longer average disease duration (12.9±9.5 years vs. 11.4 ±9.8, p=0.0136) and were slightly older (38.4±11.2 years vs. 37±10.8, p= 0.052) than oral antipsychotic treated patients. At 24 months, based on Kaplan-Meier survival analysis, 81.8% (95% confidence interval [CI]= 79.5–83.9) of RLAI patients versus 63.4% (CI=56.9–69.1) of oral antipsychotic patients (p<0.0001) were maintained on original treatment. The multivariate proportional hazards regression controlling patient difference showed that discontinuation hazard ratio (HR) was 2.30 (CI=1.79–2.97, p<0.0001) for oral antipsychotic users compared to RLAI patients.

Conclusions: Results from this 2-year prospective, observational trial show that patients treated with RLAI

are two-times more likely to remain on original treatment than those treated with oral antipsychotics.

REFERENCES:

1. Lieberman, JA, Stroup, TS, McEvoy, JP, Swartz, MS, Rosenheck, RA, Perkins, DO, Keefe, RS, Davis, SM, Davis, CE, Lebowitz, BD, Severe, J, Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators. (2005). Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med, 353, 1209–1223.
2. Olivares J et.al. 12-month treatment discontinuation rates in patients with schizophrenia treated with risperidone long-acting injection (RLAI): Interim results from observational studies conducted in Spain, Australia, and Belgium. Poster presented at ISPOR US, Arlington, Virgina, USA, May 2007.

Poster 61 **Friday, October 12 8:30 a.m.-10:00 a.m.**

RISPERIDONE LONG-ACTING INJECTION IN THE TREATMENT OF SCHIZOPHRENIA IN CANADA

Supported by Ortho-McNeil Janssen Scientific Affiars

Annette Lam, M.S., *Manager, Worldwide Health Economics and Pricing, Johnson & Johnson Pharmaceutical Services, 19 Green Belt Drive, Toronto, Ontario, Canada M3C 1LP*; Norman Costigan, M.D.; Loys Ligate, M.D.; Michael Povey, M.S.

SUMMARY:

Objectives: Evaluate the outcomes of treatment with Risperidone Long-Acting Injection (RLAI) in Canadian patients enrolled in the electronic-Schizhophrenia Treatment Adherence Registry (e-STAR) and followed for at least 3-months.

Methods: E-STAR, a secure, web-based, international, long-term, observational study of patients with schizophrenia who initiated RLAI during routine management collects data retrospectively and prospectively.

Results: To date 51 patients have been followed for 3 months. Majority were male (66.7%) diagnosed with schizophrenia or schizoaffective disorder (92.2%). At 3-months, 98% of patients were still on RLAI. Comparing the 3-month prospective period to the 3-month retrospective period prior to initiating RLAI, significant decreases were seen in proportion of patients hospitalized (33.3 vs. 15.7, p=0.013) and mean number of hospitalizations per patient (0.41 vs 0., p=0.006). Mean number of days in hospital decreased (6 vs. 4 days), but did not reach statistical significance (p=0.30). By 3-months, there were improvements in the average CGI-S score (4.00 to 3.86, p=0.418) and significant improvements in GAF score (46.9 to 51.6, p=0.008) compared to baseline.

Conclusion: Based on 3-month interim results, treatment with RLAI is associated with a decrease in hospitalizations, and improvements in disease severity and functioning in patients with schizophrenia.

REFERENCES:

1. Farmer D, et.al. The Electronic Schizophrenia Treatment Adhereance Registry - e-STAR: An Electronic Registry to Evaluate Outcomes Data in Patients with Schizophrenia/Schizoaffective Disorder. Poster presented at ISPOR, Hamburg, Germanny, October 2004.
2. Kane JM, Eerdekens M, Lindenmayer J-P et.al. Long-acting injectable risperidone: efficacy and safety of the first long-acting atypical antipsychotic. Am J Psychiatry 2003; 0: 1125–32.

Poster 62 **Friday, October 12 8:30 a.m.-10:00 a.m.**

BIPOLAR PATIENTS SWITCHING FROM VALPROIC ACID TO DEPAKOTE EXTENDED-RELEASE STUDY

Supported by Abbott Laboratories

Cosme O. Lozano, M.D., *210 N. Hammes Avenue, Suite 103, Joliet, IL 60435-6688*; John Jauch, M.A.; Dennis Nakanishi, M.A.; Kathleen Linehan, B.S.N.; Kirsten Mahaffey, B.A.

SUMMARY:

Objective: To explore the compliance, tolerability, efficacy, and adverse events in Bipolar I and II patients switching from Valproic Acid to Depakote ER.

Methods: Over the course of approximately fourteen months sixteen Bipolar I and II patients who were stable and on a therapeutic level of valproic acid were identified and were switched to Depakote ER. Patients were evaluated at baseline (before switching) and at subsequent follow-up visits (after switch) using the UKU, MADRS, YMRS, and CGI-BP scales. In addition, compliance was evaluated at baseline and during subsequent visits. Descriptive analyses were used to evaluate the change in frequencies for all individual items for each scale. A paired Wilcoxon signed-Rank test was used to compare changes on these scales for all patients before and after switching from valproic acid to Depakote ER. A repeated measures test was used to assess changes in compliance at baseline and subsequent follow up visits.

Results: Descriptive analysis of data from the UKU suggests a trend in improved tolerability after switching. A paired Wilcoxon signed-Rank test showed that emotional indifference, diarrhea, and tremor measurement

were significantly different, and CGI-BP and overall compliance scores improved after switching as well.

Conclusion: This study demonstrated improved compliance, tolerance, and CGI-BP scores after switching from valproic acid to DVPX ER.

REFERENCES:

1. Berk, M. & Berk, L. (2004) Mood stabilizers and treatment adherence in bipolar disorder; addressing adverse events. Annals of Clinical Psychiatry, 15(3–4), 217–224.
2. Bowden, C.L., Calabrese, J.R., McElroy, S.L., Gyulai, L., Wassef, A., Petty, F., Pope, H.G. Jr, Chou J.C., Keck, P.E. Jr, Rhodes, L.J., Swann, A.C., Hirshfield, R.M., Wozniak, P.J. (2000). A randomized double blind placebo controlled 12 month trial of divalproex sodium and lithium in the treatment of outpatients with bipolar disorders. Archives of General Psychiatry, 57, 481–489.

Poster 63 **Friday, October 12 8:30 a.m.-10:00 a.m.**

A RANDOMIZED, DOUBLE-BLIND, PLACEBO CONTROLLED TRIAL OF QUETIAPINE WITH FLUOXETINE IN MAJOR DEPRESSIVE DISORDER

Supported by AstraZeneca Pharmaceuticals

Jose Martinez, M.A., *Research Scientist, Department of Psychiatry, Mount Sinai School of Medicine, 1428 Madison Avenue, New York, NY 10029*; Karl Rickels, M.D.; Maurizio Fava, M.D.; Amir Garakani, M.D.; Sue Marcus, Ph.D.; James Weaver, Ph.D.

SUMMARY:

Introduction: The goal of our study was to investigate whether quetiapine, when compared to placebo, can speed the onset of action and improve the quality of response to fluoxetine treatment in patients suffering from a major depressive disorder (MDD).

Methods: A total of 114 patients with MDD were enrolled in an 8-week treatment study. Patients were treated with fluoxetine and randomized to quetiapine or placebo. Quetiapine was flexibly dosed starting at 25mg to a maximum of 100mg daily.

Results: Mixed-effects linear regression of treatment efficacy based on MADRS score showed that the quetiapine plus fluoxetine group improved significantly more rapidly than the fluoxetine plus placebo group: from baseline to week 1 (P=0.005) and to week 2 (P=0.04). Mixed-effects linear regression of insomnia score showed that the quetiapine plus fluoxetine group improved significantly more rapidly compared to the fluoxetine plus placebo group: from baseline to week 1 (P= 0.00055), week 2 (P=0.0004), week 3 (P=0.01), week 5 (P=0.0341), and week 8 (P=0.0458).

Conclusion: The study indicates that combining quetiapine with fluoxetine improved efficacy of treatment and improved sleep over fluoxetine alone.

REFERENCES:

1. Devarajan S, Ali J, Dursun SM. Quetiapine plus SSRI in treatment-resistant depression: possible mechanisms. Psychopharmacology (Berl) 2006; 185:402–3.
2. McIntyre A, Gendron A, McIntyre A. Quetiapine adjunct to selective serotonin reuptake inhibitors or venlafaxine in patients with major depression, comorbid anxiety, and residual depressive symptoms: a randomized, placebo-controlled pilot study. Depress Anxiety. In press, 2007

Poster 64 **Friday, October 12 8:30 a.m.-10:00 a.m.**

WOMEN AND ALCOHOLISM: A META-ANALYSIS OF OUTCOME PREDICTORS FOR ACAMPROSATE

Supported by Forest Laboratories, Inc.

Eugene J. Schneider, M.D., *Associate Director, Clinical Development and Medical Affairs, Forest Laboratories, Inc., Harborside Financial Center, Plaza V, Jersey City, NJ 07311*; Barbara Mason, Ph.D.; Philippe Lehert, Ph.D.

SUMMARY:

Background: Research shows that alcoholism manifests differently in women and men. However, considerably less is known about the factors influencing treatment outcome in women.

Methods: Fifteen double-blind, placebo-controlled trials of acamprosate were selected according to predetermined criteria. Predictors of outcome, defined as percent days abstinent (PDA), were estimated using individual patient data meta-analysis techniques and data collected from the 955 women participating in these trials.

Results: At baseline compared to men, women had accelerating dependence severity, including higher alcohol consumption and increased levels of liver enzymes, as well as higher rates of past suicide attempts, anxiety, and depression. However, none of these baseline characteristics were found to significantly influence treatment outcome. Instead, PDA was significantly correlated with: baseline motivation for abstinence, abstinence at baseline, family support, and treatment with acamprosate (all $P<.001$, including study factor). Further analyses showed a highly significant interaction between compliance and treatment outcome ($P<.01$).

Conclusions: Women responded to treatment comparably to men, despite greater baseline severity of psychi-

atric history and alcohol dependence. Abstinence duration in women may be significantly improved by prescribing acamprosate to patients who are abstinent at treatment initiation, and in conjunction with techniques that increase motivation, enhance medication compliance, and encourage family support.

REFERENCES:

1. Anton RF, O'Malley SS, Ciraulo DA, Cisler RA, Couper D, Donovan DM, Gastfriend DR, Hosking JD, Johnson BA, LoCastro JS, Longabaugh R, Mason BJ, Mattson ME, Miller WR, Pettinati HM, Randall CL, Swift R, Weiss RD, Williams LD, Zweben A, COMBINE Study Research Group: Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. JAMA 2006;295: 2003–2017.
2. Mason BJ: Acamprosate in the treatment of alcohol dependence. Expert Opin Pharmacother 2005;6: 2103–2115.

Poster 65 **Friday, October 12 8:30 a.m.-10:00 a.m.**

ATYPICAL ANTIPSYCHOTIC DRUG-INDUCED ACUTE LARYNGEAL DYSTONIA

Sandeep Mellacheruvu, M.D., *House Officer, Department of Psychiatry and Human Behavior, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216*; John Norton, M.D.; John Schweinfurth, M.D.

SUMMARY:

Acute laryngeal dystonia (LD) can be a life-threatening side-effect of antipsychotic medications, especially when administered parenterally. This condition requires rapid diagnosis and aggressive management with parenteral anticholinergics or benzodiazepines, as well as careful monitoring. Antipsychotics block dopamine two receptors and with that run the risk of akathisia, Parkinsonism, dystonia, neuroleptic malignant syndrome, and tardive dyskinesia. To date, there have been no case reports of intramuscular atypical antipsychotics causing acute laryngeal dystonias in the literature. A Medline search performed on 12/21/05 revealed 28 case reports of dystonia secondary to the use of both oral and intramuscular typical antipsychotics. The following cases highlight the development of LD in patients on intramuscular (IM) Ziprasidone. The risk benefit ratio of parenteral antipsychotics should be considered in the treatment of acute agitation or psychosis to minimize the risk of complications such as laryngeal dystonia.

REFERENCES:

1. Christodoulou C, Kalaitzi C. Antipsychotic drug-induced acute laryngeal dystonia: two case reports and a mini review. J Psychopharmacol. 2005 May; 19(3):307–11.
2. Koek RJ, Pi EH. Acute laryngeal dystonic reactions to neuroleptics. Psychosomatics. 1989; 30:359–364.

Poster 66 **Friday, October 12 8:30 a.m.-10:00 a.m.**

DELAYED RELEASE DIVALPROEX FOR BORDERLINE PERSONALITY DISORDER

Supported by Abbott Laboratories

Michael Miller, Ph.D., *Assistant Professor, Department of Psychiatry, University of Minnesota, 2450 Riverside Avenue, Minneapolis, MN 55454*; Richelle Moore, Ph.D.; Ann Romine, R.N.; Sue Song; Charles S. Schultz, M.D.

SUMMARY:

Introduction: Borderline personality disorder is a significantly serious mental illness which affects approximately 1% of the population. Symptoms include emotional dysregulation, mood lability, and impulsivity. Some studies have shown symptom reduction with mood stabilizing agents and with the development of delayed-release divalproex a test in BPD patients was warranted.

Methods: This report describes a double-blind, random-assignment, placebo-controlled study of delayed-release divalproex for BPD patients who were also participating in dialectical behavior therapy (DBT) treatment. All subjects received consolidated DBT.

Results: The patients included 17 research subjects who all signed written informed consent. Two subjects had a rapid response to the first four weeks of DBT and were thus followed without being randomized. 10 subjects were assigned to delayed-release divalproex and five subjects to placebo. Analysis of the results indicate a statistically significant reduction in symptoms for both the medication and the placebo group. There was no statistically significant difference between the two groups. Side effects for those subjects assigned to delayed-release divalproex including weight gain, sedation, and insomnia.

Discussion: In this pilot study of delayed-release divalproex there was no statistically significant difference between the active compound or placebo, although both groups improved significantly. The study illustrates the potential of a strategy in which all subjects are exposed to consolidated DBT before entering a research trial, as 2 of the 17 subjects remitted prior to randomization.

REFERENCES:

1. Schulz, S.C., Camlin, K.L., Berry, S.A., Jesberger, J.A. Olanzapine Safety and Efficacy in Patients with Borderline Personality Disorder and Comorbid Dysthymia (1999). Biol Psychiatry 46:1429–1435.
2. Schulz, S.C., Adityanjee, Romine, A. Atypical Antipsychotic Medications for Borderline Personality Disorder: What's the Story? (2004). Current Psychosis and Therapeutics Reports 2;93–98.

Poster 67 **Friday, October 12 8:30 a.m.-10:00 a.m.**

METABOLIC OUTCOMES AFTER TREATMENT WITH PALIPERIDONE EXTENDED-RELEASE TABLETS FOR 52 WEEKS

Supported by Johnson & Johnson Pharmaceutical Services

Dean Najarian, Pharm.D., *BCPP, Employee, Ortho-McNeil Janssen Scientific Affairs, LLC, 1771 West Street, Wrentham, MA 02093*; Marielle Eerdekens, M.D., M.B.A.; Rosanne Lane, M.S.C.; Pilar Lim, Ph.D.; Joseph M. Palumbo, M.D.

SUMMARY:

Introduction: Evaluated here are the effects of paliperidone extended-release tablet (paliperidone ER) on metabolic parameters during 52-week, open-label extension (OLE) phases of three, 6-week, double-blind (DB) trials of schizophrenia patients.

Methods: Patients (=18y) received flexibly dosed paliperidone ER (3, 6, 9, 12 or 15mg; starting dose=9mg). All samples were collected under standardized fasted conditions.

Results: The population (n=1083), mean±SD age= 37. 6±10.9, had the following OLE baseline laboratory values: glucose=5.3±1.1mmol/L, insulin= 11.0±15.5μu/ml, cholesterol=4.9±1.0mmol/L, high density lipoprotein (HDL)=1.2±0.3mmol/L, low density lipoprotein (LDL)=3.0±0.9mmol/L, triglycerides (TAG)=1.5±0.9 mmol/L, BMI=26.4±6.2kg/m2 and bodyweight=76.4± 19.7kg. Mean±SD duration in OLE was 231.8±145.68 days; mean modal dose of paliperidone ER=10.1mg. Mean end point change in serum glucose was 0.2±1.3mmol/L and insulin was 2.8±37.0μu/ml. Five patients had glucose levels outside the range 2.22–.65mmol/L (4 high, 1 low). No increases in mean total cholesterol, TAG, LDL or HDL were observed at end point. Mean end point changes in bodyweight and BMI were 1.1±5.5kg and 0.4±2.0kg/m2, respectively. No patients discontinued due to glucose-related AEs, however, 2 patients discontinued due to weight increase. The incidences of these AEs were low (<1% and 5%, respectively).

Conclusion: Data from 1-year treatment with paliperidone ER continue to support the favorable metabolic profile observed in the short-term DB studies.

REFERENCES:

1. Meyer J, et.al: Metabolic effects of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: three pooled 6-week placebo-controlled studies. Int J Neuropsychopharmacol 2006; 9 (Suppl 1):S282.
2. Meltzer H, et.al: Efficacy and tolerability of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: three pooled 6-week controlled studies. Int J Neuropsychopharmacol 2006; 9 (Suppl 1):S225.

Poster 68 **Friday, October 12 8:30 a.m.-10:00 a.m.**

CLINICAL, FUNCTIONAL, AND ECONOMIC RAMIFICATIONS OF EARLY NON-RESPONSE TO ANTIPSYCHOTICS IN THE NATURALISTIC TREATMENT OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Chintan Patel, Pharm.D., *Outcomes Liaison, Medical Division, Eli Lilly and Company, Lilly Corporate Center, DC 5024, Indianapolis, IN 46285*; Haya Ascher-Svanum, Ph.D.; Allen W. Nyhuis, M.S.; Douglas E. Faries, Ph.D.; Bruce J. Kinon, M.D.; Robert W. Baker, M.D.

SUMMARY:

Objective: Compare the functional, clinical, and economic outcomes of schizophrenia patients who did and did not have early response to antipsychotic medication at 2 weeks of treatment.

Methods: This post hoc analysis used data from a 1-year, randomized open-label study. "Response" was defined as >=20% improvement on the PANSS total score from baseline; "Early Response" as >=20% improvement at 2 weeks. Early responders compared to early non-responders on standard psychiatric outcome measures and healthcare costs following 8 weeks of treatment.

Results: Almost all (90%) non-responders at 8 weeks were correctly identified at 2 weeks. Compared to early responders, early non-responders were significantly less likely to achieve symptom remission after 8 weeks of treatment with the same antipsychotic, had poorer levels of functioning, were less likely to perceive adherence with medication as beneficial, and incurred significantly higher total treatment costs.

Conclusions: In the naturalistic treatment of schizophrenia, early non-responders appear to have poorer clinical and functional outcomes, to perceive medication as less beneficial, and incur substantially higher total treatment costs compared to early responders. Findings suggest that early non-responders may benefit from change in antipsychotic to minimize prolonging exposure to sub-optimal or ineffective treatment alternatives.

REFERENCES:

1. Agid O, Kapur S, Arenovich T, Zipursky RB. Delayed-onset hypothesis of antipsychotic action – A hypothesis tested and rejected. Arch Gen Psychiatry 2003;60:1228–1235.
2. Leucht S, Busch R, Hamann J, Kissling W, Kane JM. Early-onset hypothesis of antipsychotic drug action: A hypothesis tested, confirmed and extended. Biol Psychiatry 2005;57:1543–1549.

Poster 69 **Friday, October 12 8:30 a.m.-10:00 a.m.**

TIME TO MEDICATION DISCONTINUATION OF TYPICAL ANTIPSYCHOTIC IN DEPOT AND ORAL FORMULATIONS IN THE USUAL CARE OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Chintan Patel, Pharm.D., *Outcomes Liaison, Medical Division, Eli Lilly and Company, Lilly Corporate Center, DC 5024, Indianapolis, IN 46285*; Baojin Zhu, Ph.D.; Haya Ascher-Svanum, Ph.D.; Douglas E. Faries, Ph.D.; Lizheng Shi, Ph.D.; William Montgomery, B.S.

SUMMARY:

Objective: Compare treatment with typical antipsychotics in depot versus oral formulations on time to medication discontinuation for any cause in the long-term naturalistic treatment of patients with schizophrenia.

Methods: D from a large prospective naturalistic non-interventional study of patient with schizophrenia in the U.S., conducted 7/1997–9/2003. The analytical sample included initiators haloperidol and fluphenazine in oral or depot formulations (N=299). Time to medication discontinuation during the 1-year post initiation was compared between the oral and depot formulation groups using Kaplan Meier survival analysis, Cox proportional hazard model adjusted for available patient characteristics, propensity score-adjusted bootstrapping method, and sensitivity analyses.

Results: During the 1-year post medication initiation, patients treated with depot typical antipsychotics were twice as likely to stay on the medication compared to patients treated with oral formulations (Hazard Ratio= 1.94, 95% Confidence Interval 1.28, 2.92, p=.002). Sensitivity analyses indicated that findings were robust.

Conclusion: Treatment duration-often considered a measure reflecting medication's efficacy, safety, and tolerability- appears significantly longer for patients treated with depot versus oral formulation of the same typical antipsychotic, suggesting that compared to oral formulations, depot formulations offer a meaningful adherence advantage in the treatment of patients at high risk of medication nonadherence.

REFERENCES:

1. Schooler NR: Relapse and rehospitalization: Comparing oral and depot antipsychotics. Journal of Clinical Psychiatry 64 (suppl):14–17, 2003.
2. Adams CE, Fenton MK, Quraishi S, et.al: Systematic meta-review of depot antipsychotics drugs for people with schizophrenia. British Journal of Psychiatry 179:290–299, 2001.

Poster 70 **Friday, October 12 8:30 a.m.-10:00 a.m.**

ANTIPSYCHOTIC EFFECTIVENESS BASED ON EARLY RESPONSE IN THE TREATMENT OF SCHIZOPHRENIA

Supported by Eli Lilly and Company

Chintan Patel, Pharm.D., *Outcomes Liaison, Medical Division, Eli Lilly and Company, Lilly Corporate Center, DC 5024, Indianapolis, IN 46285*; Bruce J. Kinon, M.D.; Lei Chen, M.D.; Haya Ascher-Svanum, Ph.D.; Virginia Stauffer, Pharm.D.; Sara Kollack-Walker, Ph.D.

SUMMARY:

Objective: Post-hoc analysis to assess predictive accuracy of early response/non-response at 2 weeks to subsequent response/non-response at 6 months and clinical ramifications of early response/non-response to treatment.

Methods: We used data from 5 randomized, double-blind clinical trials comparing atypical antipsychotic drugs in the treatment of moderately-ill patients with schizophrenia spectrum disorders (N=1077). ''Early response'' defined as =20% reduction in PANSS total score at 2 weeks, and ''subsequent response'' as =40% reduction. Early responders were compared to early non-responders on the likelihood of subsequent response at 6 months reduction in psychopathology, and all-cause treatment discontinuation.

Results: Compared to early responders, early non-responders were less likely to achieve subsequent response at 6 months (19% vs. 52%, $p<0.001$), showed less improvement in psychiatric symptoms (PANSS total,

p<.001), had shorter time to all-cause medication discontinuation (p<.001), and had significantly higher rates of early treatment discontinuation (52% vs. 37%, p< 0.001). High specificity (79%) and high negative predictive value (81%) were observed.

Conclusions: Early non-response to treatment with antipsychotics at 2 weeks accurately predicted subsequent non-response at 6 months. Early non-responders may benefit from a change in antipsychotic regimens to minimize prolonged exposure to sub-optimal or ineffective treatment.

REFERENCES:

1. Agid O, Kapur S, Arenovich T, Zipursky RB. (2003) Delayed-onset hypothesis of antipsychotic action. A hypothesis tested and rejected. Arch. Gen. Psychiatry, 60: 1228–1235.
2. Correll CU, Malhotra AK, Kaushik S, McMeniman M, Kane JM. (2003) Early prediction of antipsychotic response in schizophrenia. Am. J. Psychiatry, 0: 2063–2065.

Poster 71 **Friday, October 12 8:30 a.m.-10:00 a.m.**

REDUCED SUICIDAL IDEATION, VIOLENT BEHAVIOR, AND SELF-INJURY AFTER TREATMENT WITH RISPERIDONE LONG-ACTING INJECTION

Supported by Janssen-Cilag, Czech Republic, and Slovakia

Annette Lam, M.S., *Manager, World Health Economics and Pricing, Johnson & Johnson Pharmaceutical Services*; Michael Povey, M.S.; Jan Pecenak, M.D., Ph.D.

SUMMARY:

Objectives: Examine whether there is a reduced incidence of suicidal ideation, violent behavior, and deliberate self-harm in patients with schizophrenia after 12-months of treatment with risperidone long-acting injection (RLAI) enrolled in the electronic-Schizophrenia Treatment Adherence Registry (e-STAR) in the Czech Republic and Slovakia.

Methods: E-STAR, a secure web-based, international, observational study of patients with schizophrenia who have been initiated with RLAI collects data retrospectively (1 year) and prospectively (2 years). In this analysis, 12-month follow-up data from the Czech Republic and Slovakia were pooled.

Results: 280 patients have been followed for at least 12-months (156 Czech Republic, 124 Slovakia). Majority were males (57.9%) diagnosed with schizophrenia or schizoaffective disorder (85.7%, 14.3% respectively), mean age of 37±12.1 years, and mean time since diagnosis of 9.2±9 years. Compared to baseline, significant decreases were observed in the occurrence of suicidal ideation (18% to 1.1%, p<0.001), violent behavior (15.5% to 0.4%, p=0.001), and self injury (8.6% to 0.4%, p<0.001). Individual country results were consistent with the pooled results.

Conclusion: Patients treated with RLAI for at least 12 months experienced significant decreases in the incidence of suicidal ideation, violent behavior, and self injury. Follow-up is ongoing until 24 months.

REFERENCES:

1. Haw, et.al. Suicide Life Threat Behav. 2005; 31:50–62.
2. Swanson, et.al. Arch Gen Psych. 2006;63: 490–9.

Poster 72 **Friday, October 12 8:30 a.m.-10:00 a.m.**

REMISSION IN PATIENTS TREATED WITH RISPERIDONE LONG-ACTING INJECTION

Supported by Janssen-Cilag, Czech Republic, and Slovakia

Annette Lam, M.S., *Manager, World Health Economics and Pricing, Johnson & Johnson Pharmaceutical Services*; Michael Povey, M.S.; Jan Pecenak, M.D., Ph.D.

SUMMARY:

Objective: Assess remission in patients enrolled in the electronic-Schizophrenia Treatment Adherence Registry (e-STAR) in the Czech Republic and Slovakia.

Methods: E-STAR, a secure web-based, international, observational study of patients with schizophrenia who initiated RLAI collects data both retrospectively (1 year) and prospectively (2 years). Prospective patients are evaluated for the following symptoms: delusions, conceptual disorganization, hallucinatory behavior, mannerisms and posturing, unusual thought content, blunted affect, passive/apathetic social withdrawal, lack of spontaneity, and flow of conversation. Patients in whom all of these symptoms are absent, minimal or mild and within normal boundaries, stable, and do not interfere with thinking, social relations, and behavior or functioning, were considered to be in cross-sectional remission and if this persisted for at least 6-months, they were considered to be in remission.

Results: Currently, 280 patients have been followed for 12-months. Patients who met the criteria for cross-sectional remission increased from 2.4% at baseline to 37.9% at 12-months. At 12-months, 20.6% of patients met the criteria for illness remission.

Conclusions: Based on 12-month interim results, more than one-third of patients achieved cross-sectional

remission and 20% achieved illness remission after initiating RLAI.

REFERENCES:

1. Andreasen, et.al. Am J. Psy. 2005; 2:441–449.
2. Margolese, et.al. Schiz Research. 2006; 83:65–75.

Poster 73 **Friday, October 12 8:30 a.m.-10:00 a.m.**

DISTINCT RESPONSE PROFILES, PATIENTS WITH BIPOLAR 1 DISORDER: CLUSTER ANALYSIS APPROACH

Supported by Eli Lilly and Company

Kevin Piezer, R.Ph., *BCPP, Medical Liaison Consultant, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Ilya Lipkovich, Ph.D.; John P. Houston, M.D., Ph.D.; Jonna Ahl, Ph.D.

SUMMARY:

Objective: Characterize treatment response in bipolar mania by identifying groups of patients with similar response profiles.

Methods: Patients (n=222) were from a randomized, double-blind study of olanzapine or divalproex treatment in bipolar I disorder, manic or mixed episode. Hierarchical clustering identified groups of patients based on Young-Mania Rating Scale (YMRS) scores at 5 assessments over 7 weeks. Logistic regression identified baseline predictors for cluster membership.

Results: Four distinct clusters of patients identified: Cluster 1 (n=64), patients did not maintain a response; Cluster 2 (n=92), patients responded rapidly (within a week) and response was maintained; Cluster 3 (n=36), patients responded rapidly but relapsed soon; Cluster 4 (n=30), patients responded slowly (=2 weeks) and response was maintained. YMRS Item 10 (Appearance) and psychosis were significant predictors for Clusters 1/4 vs. Clusters 2/3. Mixed index episode predicted membership in Clusters 2/3 vs. Clusters 1/4; and more prominent depressive symptoms and number of previous manic episodes were predictors for Cluster 3 vs. 2.

Conclusions: Treatment response profiles were predicted by clinical features at baseline. Presence of features may indicate risk factors for relapse in patients who have responded to treatment and should be considered prior to discharge.

REFERENCES:

1. Tohen M, Baker RW, Altshuler LL, Zarate CA, Suppes T, Ketter TA, Milton DR, Risser R, Gilmore JA, Breier A, Tollefson GA. Olanzapine versus divalproex in the treatment of acute mania. Am J Psychiatry 2002; 159:1011–1017.
2. Tohen M, Ketter TA, Baker RW, Zarate CA, Suppes T, Frye M, Altshuler L, Zajecka J, Schuh LM, Risser R, Brown E, Baker RW. Olanzapine versus divalproex sodium for the treatment of acute mania and maintenance of remission: a 47-week study. Am J Psychiatry 2003; 0:1263–1271.

Poster 74 **Friday, October 12 8:30 a.m.-10:00 a.m.**

IMPROVED MEDICATION ADHERENCE IN THE DEVELOPMENTALLY DELAYED POPULATION WITH AN EXTENDED-RELEASE DOSAGE FORM OF DIVALPROEX AND THE EFFECT OF RESIDENCE ON MEDICATION COMPLIANCE: A 30-MONTH, LONGITUDINAL REVIEW

Supported by Abbott Laboratories

Lawrence Plon, Pharm.D., M.A., *Pharmacist Specialist, University of California, Irvine Medical Center, Building 3, Room 209, 101 The City Drive, Orange, CA 92868*; Paul Touchette, Ed.D.; Curt Sandman, Ph.D.; Anne Tournay, M.D.; David Walsh, Ph.D.; Ira Lott, M.D.

SUMMARY:

Introduction: We sought to determine if residence, age, polypharmacy, sex, or valproic acid dosage forms effect medication adherence.

Method: Records for 2,229,970 prescriptions filled from 1/2000 to 6/2002 for the Medicaid patient population of Orange County, California, were cross-referenced to isolate the medication utilization of the Developmentally Delayed clients of the Regional Center. A population of 1,765 clients was identified representing 84,176 psychoactive drug prescriptions filled during the study period. Based on prescriber instructions and the number of doses dispensed, calculations were performed to determine if the prescriptions were filled on schedule. Adherence to medication was defined as maintaining a refill rate (ratio=number of days of drug supply/number of days from first fill to last fill) between 0.75 and 1.10 over the 30-month period. Client's living arrangements were divided into private home (living with parent/guardian, independently, or in a supported living arrangement) or in a community care facility (CCF). Intermediate and skilled nursing facilities were not included. It was not possible to determine if the medication was utilized for seizure control or mood stabilization

Results: Age, sex or polypharmacy had no statistically significant effect on adherence rate. Considering all valproic acid drug forms together, residence has a signifi-

cant effect on adherence rate ($p < 0.00005$). Non-compliance was 6.19 times more likely in private homes than in CCFs. There was a statistically significant lower clients' adherence when maintained on divalproex enteric coated (74.4%) when compared to the once daily dosing form (85.3%), ($p < 0.0001$). Patients on the extended release divalproex formulation are 2.01 times more likely to adhere than those on the divalproex enteric formulation.

Conclusions: For this population, the type of residence influenced medication adherence. A once-a-day formulation of divalproex had statistically improved compliance.

REFERENCES:

1. Lott et.al: Logitudinal prescribing patterns for psychoactive medications in community-based individuals with developmental disabilities: utilization of pharmacy records. Journal of Intellectual Disability Research. 2004; 48:563–571.
2. Stolker, J.J., et.al:Psychotropic drug use in intellectually disabled group-home residents with behavioral problems. Pharmcopsychiatry 2002;35:19–23.

Poster 75 **Friday, October 12 8:30 a.m.-10:00 a.m.**

POTENTIAL EFFECTS OF PAROXETINE ON THE PHARMACOKINETICS OF PALIPERIDONE EXTENDED-RELEASE TABLETS

Supported by Johnson & Johnson Pharmaceutical Services

John Prosser, Ph.D., M.B.A., *Employee, Ortho-McNeil Janssen Scientific Affairs, 8008 Chickasaw Trail, McKinney, TX 75070*; Adriaan Cleton, Ph.D.; Iris van de Vliet, B.S.C.; Ilsung Chang, Ph.D.; Paul van Hoek, M.D.; Marielle Eerdekens, M.D., M.B.A.

SUMMARY:

Introduction: This study assessed the effect of paroxetine, a potent CYP2D6 inhibitor, on the pharmacokinetics of a single dose of paliperidone extended-release (ER) tablets.

Methods: Healthy male subjects received, in random order, the following 2 treatments separated by a washout period of at least 14 days: paliperidone ER 3mg (Day 1), or 20mg of paroxetine daily (Days 1–13) with paliperidone ER 3mg on Day 10. Pharmacokinetic measurements were taken over 96h after paliperidone ER administration (Cmax and AUC8).

Results: Sixty subjects were enrolled; 83% completed the study. A slight increase in exposure, reflected by a ratio of 1.09 for Cmax (90% CI 0.98–1.22) and a ratio of 1. for AUC8 (CI 1.04–1.30) was observed when paliperidone ER was administered concomitantly with paroxetine compared with paliperidone ER alone. This was not considered clinically relevant. There were no serious AEs or clinically important individual mean changes in clinical laboratory values, vital signs, or ECG parameters.

Conclusion: Co-administration of paliperidone ER and paroxetine compared with paliperidone ER alone caused a minimal increase in paliperidone exposure that was not considered clinically relevant. Thus, the initiation or discontinuation of treatment with a CYP2D6 inhibitor does not warrant a dose adjustment of paliperidone ER.

REFERENCES:

1. Meltzer H, et.al: Efficacy and tolerability of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: three pooled 6-week controlled studies. Int J Neuropsychopharmacol 2006; 9(Suppl 1):S225.
2. Vermeir M, et.al: Absorption, metabolism and excretion of a single oral dose of 14C-paliperidone 1mg in healthy subjects. Eur Neuropsychopharmacol 2005; 30(Suppl):S191–S192.

Poster 76 **Friday, October 12 8:30 a.m.-10:00 a.m.**

EVALUATION OF QT/QTC INTERVALS AFTER ADMINISTRATION OF PALIPERIDONE EXTENDED-RELEASE AND QUETIAPINE

Supported by Johnson & Johnson Pharmaceutical Services

John Prosser, Ph.D., M.B.A., *Employee, Ortho-McNeil Janssen Scientific Affairs, 8008 Chickasaw Trail, McKinney, TX 75070*; Adriaan Cleton, Ph.D.; An Vandebosch, Ph.D.; Jaya Natarajan, Ph.D.; Stefaan Rossenu, Ph.D.; Marielle Eerdekens, M.D., M.B.A.

SUMMARY:

Introduction: This 12-day, randomized, double-blind, placebo-controlled, parallel-group, multicenter study evaluated effects of paliperidone extended-release tablets (paliperidone ER) and quetiapine on QTcLD.

Methods: After a 6-day washout, patients with schizophrenia or schizoaffective disorder were hospitalized (n=109), received moxifloxacin 400mg and randomized to increasing doses of paliperidone ER once daily: 12mg, 15mg and 18mg; or quetiapine twice daily: 200mg, 400mg, 600mg and 800mg; or placebo. Primary outcome measure was changed from baseline for QT interval corrected using a population-specific linear-derived

method at individual's tmax (?QTcLD); a non-inferiority criterion of 10msec was applied.

Results: Mean ?QTcLD at individual tmax (Day 6) for paliperidone ER 12mg (1.71msec) was estimated to be 4.35msec lower (90%CI –8.34, –0.36) than quetiapine (6.06msec) 400mg twice daily. Mean ?QTcLD at individual tmax (Day 11) for paliperidone ER 18mg (3.70msec) was 1.87msec lower (90%CI –6.24, 2.51) than quetiapine (5.57msec). Adverse event (AE) incidence was 95%=quetiapine and 82%=paliperidone ER. No AEs suggestive of arrhythmia or clinically significant cardiovascular AEs were observed.

Conclusions: Paliperidone ER (12 and 18mg) and quetiapine (800mg) slightly prolonged QTcLD interval; however, prolongation observed with paliperidone ER at tmax, even at the supratherapeutic dose of 18mg, was not clinically relevant and was comparable to that observed with quetiapine.

REFERENCES:

1. Meltzer H, et.al: Efficacy and tolerability of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: three pooled 6-week controlled studies. Int J Neuropsychopharmacol 2006; 9(Suppl 1):S225.
2. Eerdekens M, et.al: Efficacy and tolerability of oral paliperidone extended-release tablets in the treatment of acute schizophrenia: pooled data from three 52-week, open-label extension studies. Poster presented at International Congress on Schizophrenia Research 2007. Poster number 290.

Poster 77 **Friday, October 12 8:30 a.m.-10:00 a.m.**

RANDOMIZED WITHDRAWAL TRIAL OF FLIBANSERIN FOR HYPOACTIVE SEXUAL DESIRE DISORDER

Supported by Boehringer Ingelheim Pharmaceuticals, Inc.

Robert Pyke, M.D., Ph.D., *Director, Clinical Operations, Boehringer Ingelheim Pharmaceuticals, Inc., 900 Ridgebury Road, Ridgefield, CT 06877*; Evan R. Goldfischer, M.D.; Jaromir Mikl

SUMMARY:

Introduction: Hypoactive Sexual Desire Disorder (HSDD) is a common problem. This is the first randomized treatment withdrawal trial, and the first one-year controlled trial, in women with HSDD. It is assessing the efficacy and safety of a centrally acting non-hormonal agent, flibanserin.

Methods: At 65 sites in North America, pre-menopausal women with generalized, acquired HSDD for > 6 months were treated if they were in a stable, monogamous heterosexual relationship for >1 year, completed the e-Diary For HSDD Trials daily in 4 weeks of screening, and had no interfering medical problems. Open-label flexible dosing for 24 weeks led, for those meeting enrichment criteria, to randomized, double-blind, placebo-controlled treatment for another 24 weeks. Co-primary endpoints were mean change in monthly satisfying sexual events and desire score.

Results: Of 1,156 women enrolled, 731 were treated; 58.5% completed the open-label period.

Conclusion: Randomization is complete for the Rose study, a placebo-controlled randomized withdrawal trial of a centrally acting non-hormonal agent, flibanserin, for generalized, acquired HSDD in pre-menopausal women.

REFERENCES:

1. Sills T et.al. The Sexual Interest and Desire Inventory - Female (SIDI-F): Item Response Analyses of Data from Women Diagnosed with Hypoactive Sexual Desire Disorder. J Sex Med 2005; 2: 801–818.
2. Basson R et.al. Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. J Urol 2000; 3: 888–893.

Poster 78 **Friday, October 12 8:30 a.m.-10:00 a.m.**

DOSE TRENDS IN ATYPICAL ANTIPSYCHOTIC TREATMENT OF SCHIZOPHRENIA AND BIPOLAR DISORDER

Supported by Pfizer Inc.

Jihad Rizkallah, M.D., *Regional Medical and Research Specialist, Pfizer Inc., 7381 Pinehurst Drive, Cincinnati, OH 45233*; Christopher Reist, M.D.; Lisa Mucha, Ph.D.; Brian Cuffel, Ph.D.; James Harnett, Pharm.D.; Antony D. Loebel, M.D

SUMMARY:

The present study evaluated trends in the initial, maximum, and mean daily doses for each atypical antipsychotic in schizophrenia and bipolar patients using a large retrospective claims database. Atypical antipsychotic dosage data were obtained from 32,834 schizophrenia episodes and 63,211 bipolar treatment episodes over a 5-year period (2001–2005) from Medicaid and Commercial databases. Dose trends were analyzed using autoregressive, time-series models in SAS. Significant trends in mean dose were found for newer atypical antipsychotics in the schizophrenia and bipolar episodes assessed. Ziprasidone doses in schizophrenia episodes increased significantly in Medicaid (from 107.8 to 127.3 mg/d, p

< 0.001) and Commercial (from 101.9 to 127.4 mg/d, $p < 0.001$) populations, with similar trends observed for bipolar episodes. Aripiprazole doses in schizophrenia episodes declined significantly in Medicaid (from 20.8 to .8 mg/d, $p < 0.05$) and Commercial populations (from 20.7 to .4 mg/d, $p < 0.06$), with similar trends observed for bipolar episodes. No dosage trends for older atypical antipsychotics (olanzapine, risperidone, and quetiapine) were observed. Doses of ziprasidone in schizophrenia and bipolar disorder have steadily increased over the past 5 years, while aripiprazole doses have decreased. Ziprasidone doses appear to be approaching the optimally effective range established in fixed-dose trials.

REFERENCES:

1. Davis JM, Chen N: Dose response and dose equivalence of antipsychotics. J Clin Psychopharmacol 2004;24:192–208.
2. Citrome L, Volavka J: Optimal dosing of atypical antipsychotics in adults: a review of the current evidence. Harv Rev Psychiatry 2002;10:280–291.

Poster 79 **Friday, October 12 8:30 a.m.-10:00 a.m.**

DEPAKOTE EXTENDED-RELEASE IN ADULT AUTISM

Supported by Abbott Laboratories

Nicole Feirsen, *Research Assistant, Department of Psychiatry, Mount Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029*; Jade Rusoff, B.A.; Evdokia Anagnostou, M.D.; Stacey Wasserman, M.D.; Latha Soorya, Ph.D.; Danielle Halpern, Psy.D.

SUMMARY:

Background: Autism is a severe neurodevelopmental disorder marked by impairments in social interaction, communication, and restrictive/repetitive behaviors. Individuals with autism often experience associated symptoms such as aggression, irritability, and self-injurious behavior.

Methods: Seven adults with autism, ages 18–35 years, were recruited at the Seaver and New York Autism Center of Excellence. The diagnosis was made using *DSM-IV* criteria and confirmed by the ADI-R and/or the ADOS-G. All patients received divalproex sodium ER and were seen every two weeks for 12 weeks by the study physician to monitor side effects. Outcome measures included the CGI-I, OAS M, GAF, and the YBOCS - Compulsion sub-scale. Blood-work was performed at baseline, and weeks 2, 4, and 12 to monitor blood and liver function and valproate levels. The medication was titrated up to effect and/or valproate level between 50–100 mcg/ml.

Results: Seventy-two percent of subjects were responders using the CGI-Improvement Irritability scale. There was statistically significant improvement in irritability as measured by the OAS-M Irritability subscale ($t=9.5$, $df=6$, $p=0.000$), as well as in aggression as measured by the OAS-M aggression subscale ($t=2,797$, $df=6$, $p=0.031$). There was a trend level of significance on improvement in repetitive behaviors using the YBOCS ($t=2.1$, $df=6$, $p=0.08$) and in general functioning using the GAF ($t=2.29$, $df=6$, $p=0.06$). There were no abnormalities observed in blood and liver function during this study and the medication was well tolerated.

Conclusions: Extended-release divalproex sodium was very effective in reducing irritability in our sample of adults with autism. Strong trends for improvements were also noted in repetitive behaviors and general functioning.

REFERENCES:

1. Hollander E, Soorya L, Wasserman S, Esposito K, Chaplin W, Anagnostou E. Divalproex sodium vs. placebo in the treatment of repetitive behaviors in autism spectrum disorder. Int J Neuropsychopharmacol 9(2):209–13, 2006.
2. Anagnostou E, Esposito K, Soorya L, Chaplin W, Wasserman S, Hollander E. Divalproex vs. placebo for the prevention of irritability associated with fluoxetine treatment in autism spectrum disorder. J Clin Psychopharmacol 26(4):444–6, 2006.

Poster 80 **Friday, October 12 8:30 a.m.-10:00 a.m.**

REAL-WORLD IMPACT OF SECOND-GENERATION ANTIPSYCHOTICS ON WEIGHT GAIN IN ADOLESCENTS

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Qayyim Said, Ph.D., *Division of Pharmaceutical Evaluation and Policy, College of Pharmacy, University of Arkansas for Medical Sciences, 4301 W. Markham Street, Slot 522, Little Rock, AR 72205*; Lisa Rosenblatt, M.D.; Sameer Ghate, B.Ph.; Richard Whitehead, B.S.; Diana Brixner, Ph.D.

SUMMARY:

Objective: To assess the real-world impact of second-generation antipsychotics (SGAs) on body mass index (BMI) in antipsychotic-treated adolescents using a national electronic medical record (EMR) database.

Method: Naïve monotherapy patients (12–19 years) receiving antipsychotics between February 2001 and March 2006 were identified from the EMR database; patients on clozapine or depot antipsychotic were ex-

cluded. Baseline BMI was compared with maximum post-prescription BMI; regression analysis was used to assess the difference for each SGA versus all first-generation antipsychotics (FGAs), controlling for age, gender, psychiatric diagnosis, baseline BMI, weight medications and geographic region of residence.

Results: Of the 679 eligible patients, there were 36.5% receiving an FGA (mean baseline BMI [MBB, kg/m2], 25.8), 6.6% on aripiprazole (MBB, 25.1), 17.5% on olanzapine (MBB, 25.3), 17.7% on quetiapine (MBB, 25.1), 20.0% on risperidone (MBB, 24.3) and 1.6% on ziprasidone (MBB, 30.6). Compared with FGAs, olanzapine-treated patients had a statistically significant mean increase in BMI of 1.05 kg/m2 (95% CI, 0.15–1.94). No significant increases in BMI were observed with aripiprazole, quetiapine or risperidone.

Conclusion: Antipsychotics differ in propensity to cause weight gain in adolescents. Antipsychotics without weight gain potential should be considered, especially in adolescents currently overweight or at risk for overweight.

REFERENCES:

1. Sikich L, et.al: A pilot study of risperidone, olanzapine, and haloperidol in psychotic youth: a double-blind, randomized, 8-week trial. Neuropsychopharmacology 2004; 29:133–145.
2. Ratzoni G, et.al: Weight gain associated with olan zapine and risperidone in adolescent patients: a comparative prospective study. J Am Acad Child Adolesc Psychiatry 2002; 41:337–343.

Poster 81 **Friday, October 12 8:30 a.m.-10:00 a.m.**

RANDOMIZED, DOUBLE-BLIND STUDY OF GUANFACINE EXTENDED-RELEASE IN CHILDREN AGES 6–17 YEARS OLD WITH ADHD

Supported by Shire Development, Inc.

Floyd R. Sallee, M.D., Ph.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Ml0559, Cincinnati, OH 45267-0001*; James J. McGough, M.D.; Timothy Wigal, Ph.D.; Jessica Donahue, M.P.H.; Andrew Lyne, M.S.C.; Joseph Biederman, M.D.

SUMMARY:

Objectives: Immediate-release guanfacine (a selective a2A-adrenoceptor agonist) has been shown to improve symptoms of attention-deficit/hyperactivity disorder (ADHD) in small studies. This study compared the efficacy of guanfacine extended release (GXR; SPD503) with placebo in children and adolescents aged 6 to 17 years with ADHD.

Methods: Subjects were randomized to receive 1 to 4 mg/d GXR or placebo in a double-blind study. Primary efficacy endpoint was change in total ADHD Rating Scale (ADHD-RS-IV) score. Secondary endpoints included changes in hyperactive/impulsive and inattentive ADHD-RS-IV subscale scores, improvement in Clinical Global Impression (CGI) and Parent Global Assessment (PGA) scores. Conners' Parent Rating Scale (CPRS) was used to measure duration of effect versus placebo. Adverse event data were collected.

Results: All GXR dose levels showed statistically significant reductions in mean ADHD-RS-IV; changes in both hyperactive/impulsive and inattentive subscales were also statistically significant. Changes in blood pressure, pulse rate, and electrocardiograms with GXR were small to modest. Adverse events occurring in >5% of all GXR-treated subjects included dizziness, fatigue, headache, irritability, nausea, sedation, somnolence, and upper abdominal pain.

Conclusions: GXR reduced ADHD symptoms as measured by both investigator and parent rating scales. Adverse events were mild to moderate.

REFERENCES:

1. Chappell PB, Riddle MA, Scahill L, Lynch KA, Schultz R, Arnsten A, Leckman JF, Cohen DJ: Guanfacine treatment of comorbid attention-deficit hyperactivity disorder and Tourette's syndrome: preliminary clinical experience. J Am Acad Child Adolesc Psychiatry 1995; 34:1140–1146.
2. Pliszka SR: The neuropsychopharmacology of attention-deficit/hyperactivity disorder. Biol Psychiatry 2005; 57:1385–1390.

Poster 82 **Friday, October 12 8:30 a.m.-10:00 a.m.**

INTERIM RESULTS OF A LONG-TERM, OPEN-LABEL STUDY OF GUANFACINE EXTENDED-RELEASE IN CHILDREN AND ADOLESCENTS AGED 6–17 YEARS OLD WITH ADHD

Supported by Shire Development, Inc.

Floyd R. Sallee, M.D., Ph.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Ml0559, Cincinnati, OH 45267-0001*; James J. McGough, M.D.; Timothy Wigal, Ph.D.; Jessica Donahue, M.P.H.; Andrew Lyne, M.S.C.; Joseph Biederman, M.D.

SUMMARY:

Objective: Immediate-release guanfacine is a selective a2A-adrenoceptor agonist shown to improve attention-deficit/hyperactivity disorder (ADHD) symptoms in small studies. This ongoing multicenter open-label ex-

tension study assessed the long-term safety and efficacy of new guanfacine extended release (GXR) in the treatment of children and adolescents aged 6 to 17 years with ADHD.

Methods: Patients received GXR starting at 1 mg/d, increased by 1-mg/wk increments to an optimal dose (maximum 4 mg/d), and stayed at that dose until Month 23. Doses were then tapered in 1-mg/wk decrements. Safety was assessed by adverse events (AEs), laboratory tests, electrocardiograms (ECGs), and physical examination. Efficacy was measured by change in ADHD Rating Scale-IV (ADHD-RS-IV) total score at endpoint. Interim results are reported through Month 11.

Results: Thirteen (5%) of 259 patients experienced 17 serious AEs, all brief and resolved, most commonly somnolence, headache, upper respiratory tract infection, fatigue, and sedation. Mean ADHD-RS-IV changes at interim endpoint were statistically significant and clinically meaningful: −18.1 (P=.003) for 1 mg, −22.4 (P<.001) for 2 mg, 22.5 (P<.001) for 3 mg, and −20.5 (P<.001) for 4 mg.

Conclusion: AEs were mild to moderate and long-term effectiveness of GXR (up to 4 mg/d) was maintained in subjects with ADHD.

REFERENCES:

1. Hunt RD, Arnsten AF, Asbell MD: An open trial of guanfacine in the treatment of attention-deficit hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 1995; 34:50–54.
2. Waxmonsky JG: Nonstimulant therapies for attention-deficit hyperactivity disorder (ADHD) in children and adults. Essent Psychopharmacol 2005; 6:262–276.

Poster 83 **Friday, October 12 8:30 a.m.-10:00 a.m.**

EFFECT OF FIXED-DOSE ZIPRASIDONE ON WEIGHT AND METABOLIC PARAMETERS

Supported by Pfizer Inc.

Jim Smith, Ph.D., *Regional Medical and Research Specialists, 86 Crooked Creek Lane, Durham, NC 27713*; David Folks, M.D.; Ilise D. Lombardo, M.D.; Ruoyong Yang, Ph.D.; Antony D. Loebel, M.D.

SUMMARY:

Ziprasidone consistently displays a favorable metabolic profile in short- and long-term studies. The potential dose-related effects of ziprasidone on weight and other metabolic parameters have not been determined. We conducted a meta-analysis of patients with schizophrenia or schizoaffective disorder who received fixed doses of oral ziprasidone (daily dose: placebo [n = 273], = 40 mg [n = 233], 80 mg [n = 154], 120 mg [n = 125], 0 mg [n = 104], 200 mg [n = 86]) during 4 short-term, fixed-dose, placebo-controlled clinical trials. We assessed the change from baseline to last available visit for nonfasting total cholesterol, triglycerides, glucose, weight, and body mass index (BMI). Dose response was determined by using orthogonal polynomial contrasts. In an analysis of covariance (ANCOVA), the least squares mean changes from baseline for the 5 dose groups ranged from: total cholesterol (mg/dL), −3.74 to −12.12; triglycerides (mg/dL), −0.84 to −12.69; glucose (mg/dL), −1.75 to 2.24; weight (kg), 0.55 to 1.; BMI (kg/m2), 0.18 to 0.43. There were no significant dose-related effects for total cholesterol, triglycerides, glucose, weight, or BMI. These results indicate that in short-term, placebo-controlled trials, ziprasidone doses of < or = 40 to 200 mg/d are not associated with dose-related metabolic effects.

REFERENCES:

1. Simpson GM, Glick ID, Weiden PJ, Romano SJ, Siu CO: Randomized, controlled, double-blind multicenter comparison of the efficacy and tolerability of ziprasidone and olanzapine in acutely ill inpatients with schizophrenia or schizoaffective disorder. Am J Psychiatry 2004;1:1837–1847.
2. Simpson GM, Weiden P, Pigott T, Murray S, Siu CO, Romano SJ: Six-month, blinded, multicenter continuation study of ziprasidone versus olanzapine in schizophrenia. Am J Psychiatry 2005;2:1535–1538.

Poster 84 **Friday, October 12 8:30 a.m.-10:00 a.m.**

GENDER-RELATED DIFFERENCES OF BRAIN FUNCTION IN MAJOR DEPRESSION: A FUNCTIONAL MAGNETIC RESONANCE IMAGING STUDY PERFORMED BY A PERCEPTUAL ORGANIZATION PARADIGM

Thomas Sobanski, M.D., *Department of Psychiatry and Psychotherapy, Thueringen-Kliniken Saalfeld-Rudolstadt, Rainweg 68, Saalfeld, Germany 07745*; Gerd Wagner, Ph.D.; Georgios Sofianos, M.D.; Natascha Bischoff, Ph.D.; Eckart Straube, Ph.D.; Heinrich Sauer, M.D.

SUMMARY:

Introduction: Gender differences of certain clinical features in major depressive disorder (MDD) are well-established, although little is known on the neurobiological processes underlying these dissimilarities.

Methods: Our aim was to assess gender differences of regional brain function in MDD. Functional magnetic resonance imaging (fMRI) scans were performed in nine inpatients with major depression and a control group matched for age and gender. Regions of interest were: frontal lobe, hippocampus, parahippocampal gyrus, temporal and parietal lobes. FMRI scans were assessed by block design during neurocognitive stimulation with a perceptual organization paradigm. Data were analyzed by the SPM software.

Results: Male patients with MDD activated significantly stronger as female patients in the ventrolateral prefrontal cortex (PFC), in the right dorsolateral PFC, and in the anterior and posterior cingulate cortex. The opposite contrast (female > male patients) yielded no regions with stronger brain activations. Healthy controls revealed noticeably smaller sex differences.

Discussion: Our results suggest that distinct alterations of brain function underlie gender-related clinical differences in MDD. Gender differences were observed predominantly in brain structures supposed to be involved in the pathophysiology of the disease.

REFERENCES:

1. Phillips ML, Drevets WC, Rauch SL, Lane R: Neurobiology of emotion perception II: Implications for major psychiatric disorders. Biol Psychiatry 2003; 54(5):515–28.
2. Straube ER, Bischoff N, Nisch C, Sauer H, Volz HP (2002): Input dysfunction and beyond—an evaluation of CPT components. Schizophr Res 54:131–9.

Poster 85 **Friday, October 12 8:30 a.m.-10:00 a.m.**

ADRENAL INSUFFICIENCY DISGUISED AND QUETIAPINE A CULPRIT

Violeta Tan, M.D., *Resident, Department of Psychiatry, Stanford University School of Medicine, 1170 Welch Road, Apt. 724, Palo Alto, CA 94304-1914*; Natalie L. Rasgon, M.D., Ph.D.

SUMMARY:

Adrenal insufficiency oftentimes presents ambiguously. Psychotropic medications are less recognized as causative factors, contributing to this diagnostic challenge. A 54-year-old male with history of depression was re-admitted to the hospital with chief complaint of malaise. Previous admission 9 days prior was for a UTI treated with Ciprofloxacin. Patient was re-admitted for fatigue, warmth, chills, and loose stools. Physical exam was benign except for noted lethargy and tenderness to palpation in the mid-clavicular line at his 5th rib. Baseline labs were normal except for elevated eosinophils. During the first admission, his psychotropic medications, quetiapine and bupropion, were restarted since he had discontinued them 6–8 months prior. Work-up for infectious, malignant, and rheumatologic etiologies was negative. In examining endocrine causes, AM cortisol level was low at 2.5ug/mL. Cosyntropin stimulation test was performed with cortisol increasing from 4.2ug/mL to 20.4ug/mL, making primary adrenal insufficiency unlikely. Brain MRI showed no evidence of pituitary microadenoma, and testosterone, prolactin, and IGF concentrations were within normal limits. However, ACTH level was <5pg/mL, suggesting secondary or tertiary adrenal insufficiency. In reviewing the patient's medications, the potential for quetiapine to reduce ACTH and cortisol secretion was found. Prednisone 20mg qam/ 10mg qhs was initiated after which the patient's condition improved markedly. He was discharged on this dose and instructed to follow-up with an endocrinologist and his psychiatrist. This case highlights the potential effects of antipsychotics on the hypothalamic-pituitary-adrenal (HPA) axis with potentially dangerous decreases in cortisol secretion. Psychiatric disorders are more often associated with hypersecretion of cortisol and reduction in cortisol levels is commonly associated with improvement in psychopathology. Acute administration of quetiapine may contribute to marked reduction of ACTH and cortisol secretion, and recognizing this phenomenon can be critical in diagnosing and managing a potentially grave condition.

REFERENCES:

1. Cohrs S: The atypical antipsychotics olanzapine and quetiapine, but not haloperidol, reduce ACTH and cortisol secretion in healthy subjects. Psychopharmacology 2006; 185: 11–18.
2. Arlt W: Adrenal Insufficiency. The Lancet 2003; 361: 1881–1893.

Poster 86 **Friday, October 12 8:30 a.m.-10:00 a.m.**

ILOPERIDONE PHARMACOKINETICS IN CYP2D6 EXTENSIVE AND POOR METABOLIZERS

Supported by Novartis Pharmaceuticals and Vanda Pharmaceuticals

Rosarelis Torres, Ph.D., *Director of Clinical Affairs, Vanda Pharmaceuticals, 9605 Medical Center Drive, Suite 300, Rockville, MD 20850*; Curt Wolfgang, Ph.D.

SUMMARY:

Introduction: Iloperidone, a mixed D2/5-HT2 antagonist, is metabolized by CYP450 enzymes 2D6 and 3A4 (1,2). The pharmacokinetics of iloperidone were characterized in CYP2D6-genotyped extensive (EM)

and poor (PM) metabolizers, and interaction with dextromethorphan was assessed.

Methods: In a 2-cohort, open-label study, healthy subjects genotyped as CYP2D6 EM (Cohort 1, n = 19) or PM (Cohort 2, n = 8) received a single 3-mg iloperidone dose (period 1). In periods 2 and 3, Cohort 1 subjects only received 80 mg of dextromethorphan or 3 mg of iloperidone + 80 mg of dextromethorphan in random order. Plasma samples were collected at protocol specified intervals after administration of iloperidone and iloperidone + dextromethorphan. Serum samples were collected at protocol specified intervals after administration of dextromethorphan and iloperidone + dextromethorphan.

Results: Iloperidone and P88 area under the plasma concentration-time curve (AUC) values were substantially increased (57% and 95%, respectively) in PM, and P95 exposure was substantially decreased (80%). Elimination half-life was prolonged by 88% for iloperidone, 46% for P88, and 33% for P95. Pharmacokinetic parameters of iloperidone were similar in the presence or absence of dextromethorphan.

Conclusions: CYP2D6 genotyping of patients facilitates individualized prediction of the pharmacokinetic profile of iloperidone.

REFERENCES:

1. Köhler D, HäFuchs K, Sieghart W, Hiemke C. CYP2D6 genotype and phenotyping by determination of dextromethorphan and metabolites in serum of healthy controls and of patients under psychotropic medication. Pharmacogenetics. 1997;7:453–461.
2. Subramanian N, Kalkman HO. Receptor profile of P88-8991 and P95-12113, metabolites of the novel antipsychotic iloperidone. Prog Neuro-Psychopharmacol Biol Psych. 2002;26:553–560.

Poster 87 **Friday, October 12 8:30 a.m.-10:00 a.m.**

TEN YEARS OF QUETIAPINE IN CLINICAL PRACTICE

Supported by AstraZeneca Pharmaceuticals

Richard H. Weisler, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, 700 Spring Forest Road, Suite 125, Raleigh, NC 27609*; Arthur L. Lazarus, M.D., M.B.A.

SUMMARY:

Objective: To review the evolution of quetiapine from its 1997 U.S. introduction to its recent approval for bipolar depression, and discuss its current role in mental health treatment.

Methods: Data from pivotal clinical trials of quetiapine in both schizophrenia and bipolar disorder are cited, along with peer-reviewed articles on current practice recommended by the authors according to their clinical knowledge and experience.

Results: Clinical trials show that quetiapine is an efficacious and well-tolerated therapy and, over the years, its approved use has expanded from schizophrenia to both bipolar depression and acute mania. Quetiapine is regularly prescribed in primary care, where patients with bipolar disorder, especially during depressive episodes, often present. As physicians have gained more experience with the risk-benefit profile of quetiapine, the mean dosage in practice has increased(1). An extended-release formulation, which allows once-daily dosing, has been recently introduced in the U.S. for the treatment of schizophrenia(2).

Conclusion: Quetiapine, an established treatment for schizophrenia, has evolved into a well-accepted therapy for bipolar disorder with efficacy for treating depressive and acute manic episodes. Quetiapine is currently the only monotherapy approved for the acute treatment of both bipolar mania and depression in the U.S.

REFERENCES:

1. Citrome L, Jaffe A, Levine J, Lindenmayer JP. Dosing of quetiapine in schizophrenia: how clinical practice differs from registration studies. J Clin Psychiatry. 2005;66:1512–15.
2. Kahn RS, Schulz SC, Palazov V, et.al. Efficacy and tolerability of once-daily quetiapine extended release in acute schizophrenia: a randomized, double-blind, placebo-controlled study. J Clin Psychiatry (in press).

POSTER SESSION 4

Posters 88–116
Friday, October 12
3:00 p.m.-4:30 p.m.

RESEARCH IN PSYCHIATRIC SERVICES

Poster 88 **Friday, October 12 3:00 p.m.-4:30 p.m.**

UTILIZATION OF PLAN-DO-STUDY-ACT CYCLES TO IMPROVE SUBJECT SAFETY PROCESS AT A PSYCHOPHARMACOLOGY CLINIC/ CLINICAL RESEARCH CENTER

Lawrence W. Adler, M.D., *Director, Clinical Insights, 7310- Ritchie Highway, Suite 512, Glen Burnie, MD 21061-5555*; Henri Zepp, R.N.C.; Lorri Cerro, Ph.D.

SUMMARY:

Clinical Insights is a hybrid psychopharmacology practice/clinical research center. In the conduct of clinical research, human subject protection is primary. Study protocols include laboratory studies and ECGs as safety assessments. A survey of other sites revealed that these assessments are not routinely reviewed until the next subject visit. This yields a system which is 'perfectly designed' to delay detection of clinically significant abnormalities, thereby placing subjects at risk. Clinical Insights addressed this problem by utilizing Plan-Do-Study-Act (PDSA) methods described by Dr. Donald Berwick and Tom Nolan. A PDSA team was formed and ascertained a goal of 100% PI review of safety assessments within 1 working day of receipt. Baseline performance was measured each week for 2 weeks. The PDSA team then collaborated on 3 subsequent cycles of measurement, intervention, and measurement. Performance increased from 63% to 96%, and this improvement was sustainable. The poster will describe specifically the PDSA methodology and comment on its power as a tool for quality improvement.

REFERENCES:

1. Berwick DM. Developing and testing changes in delivery of care. Ann Intern Med. 1998;128:651–656.
2. Nolan TW. Understanding medical systems. Ann Intern Med. 1998;128:293–298.

Poster 89 **Friday, October 12 3:00 p.m.-4:30 p.m.**

STUDY OF MEDICAL STAFF'S COMPLIANCE ON INFORMATION SHARING WITH PATIENTS ADMITTED TO ACUTE ASSESSMENT WARD, QMC, NOTTINGHAM, ENGLAND

Adaeze Anaenugwu, M.D., M.A., *Medical Doctor, Inceptor Member, Royal College of Psychiatry, The Wells Road Centre, Nottingham, United Kingdom*; Michele Hampson, M.D

SUMMARY:

The 2005 service-users' survey by the Healthcare Commission UK, reported 93% of respondents taking medication for their mental health problems. 71% of these respondents did not feel that they had any say at all in the medications they received, with more than 1/3 not being informed about any side effects of their medication. 48% replied that they were told about the side effects only after they had already started experiencing the side effects. According to the charity, MIND, one of the frequent complaints by those who use mental health services is that they are not involved enough in decisions about their medications. Talking therapies have been listed as an effective treatment modality for people with mental illness including those with severe and enduring mental illness; however, more than 2/3 of the respondents had never been given the opportunity to discuss talking therapy as a treatment option. The Assessment ward (Ward A43) based at the QMC is an acute ward that subserves the South Nottingham population (450,000). Its purpose is for the psychiatric assessment of service-users, who require assessment in an inpatient setting and then depending on the outcome of assessment, can be transferred to one of the treatment and therapy wards or discharged with home treatment package. It has an average admission rate of 75 patients every month.

REFERENCES:

1. NICE Guidelines on treatment of Bipolar Affective Disorder.
2. Mojtabai, R; Olfson, M (2003) Medication costs, adherence and health outcomes; Health Affairs, 22, 4, 220–229.

Poster 90 **Friday, October 12 3:00 p.m.-4:30 p.m.**

EXPECTED VALUE OF RESEARCH ON COMPARATIVE COST-EFFECTIVENESS OF ANTIPSYCHOTIC DRUGS

Supported by Best Practice, Inc.

Anirban Basu, Ph.D., *Assistant Professor, University of Chicago School of Medicine, 5841 S. Maryland Avenue, MC2007, Chicago, IL 60637*; Herbert Y. Meltzer, M.D.; David Meltzer, Ph.D.

SUMMARY:

Objective: Recent results from CATIE suggest that perphenazine is more cost-effective than atypical antipsychotics in schizophrenia. Despite limitations, these results are affecting the selection of antipsychotics in the U.S. We studied the value of performing cost-effectiveness studies of typical versus atypical antipsychotics with greater precision than CATIE.

Methods: We used CATIE data to perform a probabilistic value of information analysis based on the uncertainty in the lifetime survival, costs and QALYs of initial schizophrenia treatment with perphenazine, olanzapine, risperidone, and quetiapine. The expected value of research relies on the probability that the CATIE results are incorrect (i.e. perphenazine is not the cost-effective) and the expected net monetary loss if the CATIE results are incorrect.

Results: At a threshold of $50K/QALY, the value of more precisely determining the cost-effectiveness of

atypical/typical antipsychotics in the U.S. is $320 billion, including $192 billion accruing to the prevalent cohort of schizophrenia patients and $6.15 billion for the next 20 incident annual cohorts. The probability that perphanazine is not cost-effective is 55%.

Conclusions: There is enormous value to more precisely establishing the cost-effectiveness of typical/atypical antipsychotics. The results of CATIE should not be viewed as definitive. Further studies of the comparative cost-effectiveness of typical/atypical antipsychotics are needed.

REFERENCES:

1. Rosenheck RA, Leslie DL, Sindelar J, Miller EA, Lin H, Stroup TS, McEvoy J, Davis S, Keefe R, Swartz M, Perkins D, Hsiao JK, Lieberman J. Cost-effectiveness of Second Generation Antipsychotics and Perphenazine in a Randomized Trial of Treatment for Chronic Schizophrenia. American Journal of Psychiatry. 2006 Dec:3 (12): 2080–89.
2. NewYork Times Editorial, Comparing Schizophrenia Drugs, September 21, 2005; The nation is wasting billions of dollars on heavily marketed drugs that have never proved themselves in head-to-head competition against cheaper competitors.

Poster 91 **Friday, October 12 3:00 p.m.-4:30 p.m.**

SURVEY OF THE PSYCHOLOGICAL ATTENDANCE DEMANDS ON SURGICAL PATIENTS WITH HEAD AND NECK CANCER

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Daniela Achette, B.S.; Leopolddo Barbosa, B.S.; Antonio Goncalves, D.M.

SUMMARY:

Objective: The treatments for cancer in the head and neck region are frequently aggressive and invasive, with significant psychosocial repercussions that affect patient and family. This study will aim to evaluate mainly demands for psychological intervention.

Methods: Retrospective study of 51 protocols of psychological accompaniment, with questions elaborated specifically for this population.

Results: 70% of participants were men and 30% women, with average age between 55,5 and 52 years old respectively. About the tumor localization: 50% larynx, % oral socket, 12% thyroid, 8% lips, 6% skin, 6% hypopharyngeal and 2% oropharyngeal. Identified demands (in % of answers) on the day before the surgery: 66% fear of death, 36% surgery expectation, 42% ceasing of the tobacconist and alcoholism, 38% guilt, 48% familiar concerns, 22% professional concerns, 68% self-care maintenance, 28% stigma (sounding lead and tracheostomal), and 50% implication on the treatment. On the day after surgery: adjustment to the possible communication, 70% social and familiar adaptation, 36% fear of a possible return, 52% adaptation to the corporal image changes, 18% ceasing of the tobacconist and alcoholism maintenance, 10% depression and 20% anxiety.

Conclusions: The mainly demands for psychological intervention were configured was: On the day before the surgery was: the fear of death caused by cancer, the support in the ceasing of the tobacconist and alcoholism and the active participation of the patient in its treatment; On the day before surgery the social and familiar difficulties of adaptation, mainly because of the modification on the communication and the acceptance of the corporal image changes.

REFERENCES:

1. Vickery, L. E.; Latchford, G.; Hewinson, J.; Bellew, M., Feber, T. – The Impact of Head and Neck Facial Disfigurement on the Quality of Life of Patients and Their Partners. Head and Neck, 25: 289–296, 2003.
2. Krouse, J. H.; Krouse H. J. Fabian, R. J. – Adaptation to Surgery for Head and Neck Cancer. In: Vickery, L. E.; Latchford, G.; Hewinson, J.; Bellew, M., Feber, T., The Impact of Head and Neck Cancer and Facial Disfigurement on the Quality of Life of Patients and their Partners. Head and Neck, 25: 289–296, 2003.

Poster 92 **Friday, October 12 3:00 p.m.-4:30 p.m.**

PSYCHOSOCIAL REPERCUSSIONS ON PATIENTS SUBMITTED TO TOTAL LARYNGECTOMY FOR LARYNX CANCER: A CLINIC-QUALITATIVE STUDY

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Daniela Achette, B.S.; Leopolddo Barbosa, B.S.; Antonio Goncalves, D.M.

SUMMARY:

Objective: It is known that treatments on the head and neck region cause some aesthetic and functional alteration. This study will aim to evaluate those repercussion on the performance of social rules, the emotional expression and the communication of the patients.

Methods: Through a clinic and qualitative study, we seek to understand how these repercussions affect the

patient who is submitted to the total laringectomy on the larynx cancer cases.

Results: It has become evident that the diagnosis of the cancer and the experience of the total laringectomy cause psychosocial repercussions, specifically, the social contact damage, because of the voice losing and the presence of tracheostomal. However, the perception of the treatment allowed the individuals to continue alive with the chance to restart their projects. It has made possible a positive appreciation from the patients related to the surgery. We also have noticed a passive and resigned position across from their life, presented on the patients' speech, and, on this context, aspects as religiousness, familiar support and handling of the interdisciplinary team had been considered as motivation for the treatment

Conclusions: The cancer presents multiples meanings and affects psychosocial aspects significantly on a patient's life. The team support, the clarification of doubts and the psychological support contribute for an anxiety relief and an emotional balance during the treatment and in the rehabilitation.

REFERENCES:

1. Katz, M. R.; Irish, J. C.; Devins, G. M.; Rodin, G.M. & Gullane, P. J. – Psychosocial Adjustment in Head and Neck Cancer: The Impact of Disfigurement, Gender and Social Support. Head and Neck, 25 (2): 103–112, 2003.
2. Dropkin, M. J.; Malgady, R. G.; Scott, D. S.; Oberst, M. T. & Strong, E. W. – Scaling of Disfigurement and Dysfunction in Postoperative Head and Neck Patients. In: Vickery, L. E.; Latchford, G.; Hewinson, J.; Bellew, M. & Feber, T., The Impact of Head and Neck Cancer and Facial Disfigurement on the Quality of Life of Patients and their Partners. Head and Neck, 25: 289–296, 2003.

Poster 93 **Friday, October 12 3:00 p.m.-4:30 p.m.**

FREQUENCY OF SCHIZOAFFECTIVE DISORDER DIAGNOSIS IN PATIENTS WITH PSYCHOTIC DISORDERS USING THE MINI-INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Bryan Dirks, M.D., M.S., *Associate Director, Research Physician, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Carla M. Canuso, M.D.; Colette Kosik-Gonzalez, M.D.; Amir Kalai, M.D.; Sarah Kavanagh, Ph.D.; Ramy Mahmoud, M.D.; Georges M. Gharabawi, M.D.

SUMMARY:

Background: This ongoing international study evaluated the Mini-International Neuropsychiatric Interview (MINI) for Schizophrenia and Psychotic Disorder Studies, a widely used and validated [1] psychiatric structured interview, to identify subjects with schizoaffective disorder.

Methods: Subjects between 18–65 years of age with acute or chronic psychosis were evaluated using the MINI. Subjects' charts were reviewed for prior psychiatric diagnoses.

Results: To date, a total of 178 subjects have been evaluated from four regions. By MINI, the most common diagnoses were schizophrenia, 46.0% (82/178); schizoaffective disorder, 32.6% (58/178); and mood disorders with psychotic features or mood disorders NOS, .9% (30/178). The frequency of MINI diagnosis of schizoaffective disorder ranged from 23.3% (7/30) in Ukraine to 40.8% (20/49) in Asia Pacific. Among subjects with a MINI diagnosis of schizoaffective disorder the most common chart diagnosis was schizoaffective disorder (44.8% [26/58]) followed by schizophrenia (36.2% [21/58]). The use of antipsychotic therapy(ies) alone or in combination with antidepressants and/or mood stabilizers was common across the regions.

Conclusions: Data from this interim analysis of an ongoing trial indicate a frequency of schizoaffective disorder diagnosis by MINI of 32.6%, which is consistent with the literature [2]. Both monotherapy and combination therapy were common in all regions.

REFERENCES:

1. Sheenhan DV, Lecrubier Y, Sheehan KH, et.al. The Mini-international Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview of *DSM-IV* and ICD-10. J Clin Psychiatry 1998;59 Suppl 20:22–33.
2. Perala J, et.al. Lifetime prevalence of psychotic and bipolar I disorders in a general population. Arch Gen Psychiatry 2007;64:19–28.

Poster 94 **Friday, October 12 3:00 p.m.-4:30 p.m.**

HOW USEFUL ARE PATIENT REPORTED ASSESSMENTS IN IMPROVING OUTCOMES IN SCHIZOPHRENIA? RESULTS FROM THE SCOTTISH SCHIZOPHRENIA OUTCOMES STUDY

Robert Hunter, M.Psy., *Research and Development, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, Scotland G12 0XH*; Rosie Cameron, B.A.; Robert M. Hunter, M.Psy.; John Norrie, B.A., .

SUMMARY:

A key element in recovery approaches (1) is to enable service users to assess their own needs. This information should be utilized by health care professionals when formulating care plans. An individual's perspective on their mental health must be given primacy, and individuals encouraged to take more responsibility for health issues. These approaches have been accepted in many aspects of health care, but there remains concern that models may not translate into health care settings for those with more severe forms of mental disorder such as schizophrenia. It is possible that diminished insight and cognitive impairment may affect an individual's ability to assess their own health needs. This paper reports on interventions and health outcomes over 3 years in a cohort of 1,000 participants with multi-episode schizophrenia receiving services from NHS Scotland. The Scottish Schizophrenia Outcomes Study (2) is a naturalistic, observational, longitudinal study of people, mostly living in community settings. Results will compare a range of outcomes: pragmatic; service user assessed; and clinician rated. The feasibility of using service user assessments in people with schizophrenia will be examined following concerns from some clinicians.

REFERENCES:

1. Scottish Recovery Network. www.scottishrecovery.net.
2. Hunter R and Cameron R (2006). The Scottish Schizophrenia Outcomes Study. NHS Quality Improvement; Scotland, Edinburgh.

Poster 95 **Friday, October 12 3:00 p.m.-4:30 p.m.**

FIRST MAILED INTERVENTION TO PHYSICIANS SLOWED RATE OF INCREASE IN PHARMACY COSTS

Supported by Comprehensive NeuroScience, Inc.

Jeff Veach, M.S., *Vice President, Biostatistics CNS, Comprehensive NeuroScience, Inc., One Copley Parkway, #534, Morrisville, NC 27560*; Harold Carmel, M.D.; Joseph J. Parks, M.D.;

SUMMARY:

This study assessed the effect of mailed physician intervention messages on the rate of change in psychotropic medication costs. A first mailed intervention regarding, 962 patients (adults continuously eligible for Missouri Medicaid in the study period 2002–2005 receiving psychotropic medications) was sent to the patient's physician between 6/03 and 11/04. The rate of change in psychotropic medication costs for the study period before the intervention was compared to the rate of change for the study period after intervention. Average cost/patient/month was calculated for each patient using Medicaid claims data. The analysis was based on a repeated measures analysis of covariance using mixed model methodology, using data from the first 11 mailings. Within the model, rates of change were calculated and analyzed. A statistically significant difference (p<0.0001) was observed in the rate of change before and after the intervention in each of the first 11 mailings. For the first mailing, the rate of spending increase pre-intervention was $94/12 months; post-intervention, the rate of spending increase fell to $.50/12 months. Estimated savings in the first mailing group (N=2013) was $898/patient during the first year after intervention (p<.0001, 95% CI: $780, $10). Total estimated savings due to the first mailing = $1.8 million.

REFERENCES:

1. Ning A, Dubin WR, Parks JJ: State Mental Health Policy: Finding a Role for Quality. Psychiatric Services 2005;56(8):909–911.
2. Parks J, Surles R: Best Practices: Using Best Practices to Manage Psychiatric Medications Under Medicaid. Psychiatric Services 2004;55(11):1227–1229.

Poster 96 **Friday, October 12 3:00 p.m.-4:30 p.m.**

SLEEP INSUFFICIENCY AND HOUSEHOLD DEMOGRAPHICS

Daniel P. Chapman, Ph.D., M.S.C., *Psychiatric Epidemiologist, Division of Adult and Community Health, Department of Health Care and Aging, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., Mailstop K-67, Atlanta, GA 30341*; Tara W. Strine, M.P.H.; Geraldine Perry, Ph.D.

SUMMARY:

Approximately 47 million adults are not getting sufficient sleep to be fully alert the next day. We examined potential factors related to sleep insufficiency, specifically marital status and the presence of children in the household. Data were obtained from the 2002 Behavioral Risk Factor Surveillance System, an ongoing, state-based, random-digit telephone survey of U.S. adults residing in the community. The sleep insufficiency question was administered in 18 states and the District of Columbia (n=79,576). Both married men and women with children were significantly more likely to report insufficient sleep than their gender-matched peers without children. The same was true of unmarried men and women. Additionally, married women with children were significantly more likely to report sleep insufficiency than married men with children — as were unmar-

ried women with children versus unmarried men with children. Notably, married women without children were more likely to report sleep insufficiency than married men without children. However, there was no significant difference in reported sleep insufficiency between unmarried women and men without children. These findings suggest that household composition is associated with sleep insufficiency. Sleep insufficiency is more prevalent in households with children. Moreover, women with children are more likely to report insufficient sleep than their male partners. These findings suggest the need for sleep education among families with children — particularly for mothers — and corroborate the importance of sleep as a facet of women's health.

REFERENCES:

1. Mamber R, Armitage R: Sex, steroids, and sleep: a review. Sleep 22:540–555, 1999.
2. Thorpy MJ, Korman E, Spielman AJ: Delayed sleep phase syndrome in adolescents. Journal of Adolescent Health Care 9:22–27, 1988.

Poster 97 **Friday, October 12 3:00 p.m.-4:30 p.m.**

SPORADIC CREUTZFELDT-JAKOB DISEASE AND CONVERSION DISORDER: A CASE REPORT

Catherine Chung, B.A., *Medical Student, Department of Psychiatry, State University of New York, Upstate Medical University, 750 East Adams Street, Room 1702UH, Syracuse, NY 13210*; Adekola O. Alao, M.D.

SUMMARY:

Here we report the case of Ms. H, a 46-year-old Caucasian woman with no past medical or psychiatric history who presented with complaints of slow speech, word-finding difficulties, and decreased concentration. Initial work-up including MRI and MRA, lumbar puncture, complete blood count, and basic metabolic panel were unremarkable with the exception of significantly elevated TSH levels. Symptoms were subsequently attributed to hypothyroidism. Despite treatment with levothyroxine and TSH levels that indicated a euthyroid state, Ms. H continued to experience the same cognitive difficulties resulting in repeat admission to the neurology floor. As no organic cause could be identified as the etiology of her symptoms, a psychiatric consultation was called to evaluate Ms. H for possible conversion disorder. Psychiatric evaluation revealed multiple psychosocial stressors in Ms. H's life; nonetheless, it was not believed that Ms. H's symptoms were due to conversion disorder and she was subsequently discharged home by her primary team. Ms. H presented to the Emergency Department several days later with delusions and paranoia in addition to continued slow speech and word-finding difficulty. She was subsequently admitted to the psychiatry floor to rule out a psychotic disorder. An EEG during her admission revealed abnormalities, and Ms. H was transferred to the neurology unit. Unfortunately, Ms. H's condition continued to decline without a known etiology despite aggressive work-up; eventually a repeat MRI showed new hyperintensities and a brain biopsy was performed, revealing changes consistent with spongiform encephalopathy. A diagnosis of sporadic Creutzfeldt-Jakob disease (sCJD) was later confirmed by Western blot analysis. This case demonstrates the challenge of diagnosing sCJD raised by its multiple neuropsychiatric presentations, further complicated by the fact that characteristic EEG and MRI abnormalities often do not appear until late in the disease course. Unless suspicion for sCJD is high, it may be misdiagnosed for a psychiatric disorder, including conversion disorder or a psychotic disorder.

REFERENCES:

1. Solvason HB, Harris B, Zeifert P, Flores BH, Hayward C. Psychological Versus Biological Clinical Interpretation: A Patient With Prion Disease. Am J Psychiatry 2002; 159:528–537.
2. Keshavan MS, Lishman WA, Hughes JT. Psychiatric Presentation of Creutzfeldt-Jakob Disease. British Journal of Psychiatry 1987; 151:260–263.

Poster 98 **Friday, October 12 3:00 p.m.-4:30 p.m.**

CRIMINAL JUSTICE SYSTEM INVOLVEMENT AND COSTS FOR PATIENTS TREATED FOR SCHIZOPHRENIA

Supported by Eli Lilly and Company

Trina Clark, R.Ph., M.S., *Outcomes Liaison, Medical Division, Eli Lilly and Company, Lilly Corporate Center, DC 5024, Indianapolis, IN 46285*; Haya Ascher-Svanum, Ph.D.; Allen W. Nyhuis, M.S.; Oladapo T. Tomori, M.D.; Daniel Ball, D.P.H.; Bruce J. Kinon, M.D.

SUMMARY:

Objective: To assess criminal justice system (CJS) involvement and its direct costs for individuals treated for schizophrenia.

Methods: This post-hoc analysis used data from a 1-year prospective study of schizophrenia patients in the U.S. Patients' resource utilization was used to calculate total direct treatment costs per patient per year. Patients were also interviewed about CJS involvement. Patients with and without CJS involvement were compared on

baseline characteristics and direct annual treatment costs.

Results: During the 1-year study, 46% of the participants reported at least one involvement with the CJS. The most prevalent type of involvement was being a victim of a crime, parole/probation, and arrest for assault. The mean cost of CJS involvement was $2,565, increasing the annual per patient total health care cost by 11.5%, on the average. Patients with and without CJS involvement significantly differed on demographic, clinical and functional variables.

Conclusions: Prevalent involvement with the criminal justice system is associated with additional costs that often go unaccounted for in cost studies of schizophrenia. Findings highlight the need to improve understanding of the interface between the mental health and the criminal justice systems for patients with schizophrenia and their related costs, in economic, personal and societal terms.

REFERENCES:

1. Clark RE, Ricketts SK, McHugo GJ. Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. Psychiatr Serv. 1999;50(5):641–647.
2. Lafayette JM, Frankle WG, Pollock A. et.al. Clinical characteristics, cognitive functioning, and criminal histories of outpatients with schizophrenia. Psychiatr Serv. 2000; 92 (4): 1102–1109.

Poster 99 **Friday, October 12 3:00 p.m.-4:30 p.m.**

COMFORT ROOMS: REDUCING SECLUSION AND RESTRAINT IN AN ACUTE PSYCHIATRIC FACILITY

Craig M. Coldwell, M.D., M.P.H., *Assistant Professor of Psychiatry, Dartmouth Medical School, 36 Clinton Street, Concord, NH 03301-2359*; Sylvia Grandfield, R.N.C.

SUMMARY:

National initiatives promote the reduction of seclusion and restraint use during psychiatric hospitalization. The aim of this study is to assess the effectiveness of a comfort room in decreasing seclusion and restraint use on an involuntary acute admissions unit. Authors used one-way ANOVA and statistical process control analysis of quality improvement data to compare restrictive measure outcomes on an experimental unit with a comfort room versus a control unit. Results indicate no significant changes in mean outcomes occurred with the introduction of a comfort room; however, variation analysis demonstrated a disproportionate attribution of all seclusion and restraint use to a select few "high-utilizer" patients. Severe aggression, psychosis, personality disorders and cognitive impairment characterized these at-risk individuals. Results suggest some reduction in restrictive measures for other patients. Authors conclude that comfort rooms can be helpful for most patients admitted to acute psychiatric hospitals; however, other interventions, such as aggressive psychopharmacology, may be more effective in reducing seclusion and restraint use for at-risk patients. Organizations seeking to reduce restrictive measure use should prepare an array of interventions targeted to appropriate patient subgroups.

REFERENCES:

1. Champagne T, Stromberg N: Sensory approaches in inpatient psychiatric settings: innovative alternatives to seclusion & restraint. J Psychosocial Nursing; 42(9):35–44.
2. Huckshorn KA: Reducing seclusion & restraint use in mental health settings: core strategies for prevention. J Psychosocial Nursing; 42(9):22–33.

Poster 100 **Friday, October 12 3:00 p.m.-4:30 p.m.**

EMERGENCY LINKAGE TO OUTPATIENT PSYCHIATRIC SERVICES

Supported by GlaxoSmithKline

Glenn W. Currier, M.D., M.P.H., *Associate Professor of Psychiatry and Emergency Medicine, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14534*

SUMMARY:

Design: Randomized-controlled trial of a novel intervention to link discharged Emergency Department (ED) patients who initially presented with suicidal thoughts or behaviors with their first outpatient psychiatric appointment.

Intervention: ED-based mobile crisis team which followed patients into the community within 48 hours of ED discharge. Two groups of 60 adult patients each were compared: Mobile Crisis Team [MCT] versus treatment as usual [TAU], provision of an outpatient appointment within 5 business days of ED discharge. Primary outcome was successful contact either in the community by the MCT or at scheduled appointment for TAU. Secondary outcomes: 1) Health outcomes: depression, suicidal behavior, substance abuse relapse; 2) Functional outcomes; 3) Service usage post intervention: repeat ED use, outpatient clinic attendance, or inpatient bed days; or 4) Patient satisfaction and preference data.

Results: Over 90% of eligible subjects consented to enroll in the study. Demographics mirror those of general

ED population: 57% female, 59% Caucasian, 57% with history of suicide attempts, 40% current drug users. Linkage rates for TAU group were 29.7% versus 69.7% for MCT [relative risk 2.35]. Subjects endorsed a strong preference for community-based care. However, no significant differences emerged at 2 weeks, 3 or 6 months in terms of symptoms, functional outcomes or health services usage. Use of emergency services actually increased slightly in the intervention group. Data were reexamined to compare outcomes of patients in both groups who remained in ongoing outpatient services. Again, no clinically or functionally relevant differences emerged.

Findings: Linkage of subjects to outpatient psychiatric care can be increased significantly through ED based outreach after discharge. However, salutary effects of successful linkage were not detected. Moreover, no differences emerged between subjects who remained in outpatient treatment versus those who did not. The treatment model employed in ambulatory psychiatric environments for this subpopulation of patients warrants reexamination.

REFERENCES:

1. Gao S, Biegel DE, Johnsen JA, Dyches H. Assessing the impact of community-based mobile crisis services on preventing hospitalization. Psychiatric Services, Feb 2001, 52(2):223–228.
2. Luoma JB, Martin MA, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry, June 2002, 159(6): 909–915.

Poster 101 **Friday, October 12 3:00 p.m.-4:30 p.m.**

PSYCHOACTIVE SUBSTANCE USE TO COPE WITH PSYCHIATRIC EPISODES

Gaelle Encrenaz, Ph.D., *Department of Psychiatry, Bordeaux University, 146 Rue Leo Saignat, Bordeaux, France 33076*; Viviane Kovess-Masfety, Ph.D.; Marthe-Aline Jutand, M.S.C.; Elodie Carmona, M.S.C.; David Sapinho, M.S.C.; Antoine Messiah, Ph.D.

SUMMARY:

Background: The use of psychoactive substances to self-medicate is not well documented in the general population.

Objectives: To estimate the type and frequency of health care and substance use to cope with anxiety disorders or depressive episodes, and to determine factors associated with this substance use, taking health care use into account.

Methods: Data from a survey of the French general population (n=20 077) were used. Mental episodes were determined using the CIDI-SF and subjects were asked if they had used substances and mental health care to cope with these episodes.

Results: The use of substances to self medicate was 17.4 % among men and 7.1 % among women. Mostly, subjects who used substances also used health care. Men, single persons, and the young were more likely to use substances. The likelihood of using substances and health care was increased when subjects suffered from severe disability.

Discussion: This study is of interest in helping to prevent substance use disorders, by defining two targets according to health care use.

REFERENCES:

1. Bolton, J., Cox, B., Clara, I., et.al (2006). Use of alcohol and drugs to self-medicate anxiety disorders in a nationally representative sample. J Nerv Ment Dis, 194, 818–825.
2. Mueser, K. T., Drake, R. E. & Wallach, M. A. (1998) Dual diagnosis: a review of etiological theories. Addict Behav, 23, 717–734.

Poster 102 **Friday, October 12 3:00 p.m.-4:30 p.m.**

METABOLIC SYNDROME IN TWO PSYCHIATRIC OUTPATIENT POPULATIONS

Supported by Albert Einstein College of Medicine of Yeshiva University

Christian Escobar, B.S., *Medical Student, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Bronx, NY 10461*; Larissa Chismar, B.A.; Maia Mamamtavarishvili, M.D.; Mary E. Woesner, M.D.; Judith Wylie-Rosett, Ed.D., J. Daniel Kanofsky, M.D., M.P.H.

SUMMARY:

Objective: Psychiatric patients are at high-risk for developing metabolic syndrome because of poor eating habits, low activity and use of medications that have metabolic side effects.

Methods: A cross sectional analysis was done through the following methods: a questionnaire that surveyed diet, exercise and activity, the measurement of waist circumference and body mass index (with height and weight measurements) and through chart review to appraise the presence of the criteria for metabolic syndrome. A total of 41 outpatients were surveyed in two settings at Bronx Psychiatric Center: Assertive Community Treatment (ACT) and the Ginsberg Outpatient Clinic (GOPC).

Results: Out of the 41 patients surveyed, we identified 13 (31.7%) patients who met the criteria for metabolic

syndrome, 15 (36.6%) who did not meet the criteria, and 13 (31.7%) with insufficient data. Findings were similar in both settings.

Conclusion: Metabolic syndrome is prevalent within a substantial portion of the population that was previously undiagnosed. Many more patients need to be tested and monitored to evaluate their metabolic status. Those with metabolic syndrome need to be monitored for progression of the syndrome and complications that may result.

REFERENCES:

1. Grundy SM, Cleeman JI, Daniels SR, et.al: Diagnosis and management of the metabolic syndrome. An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement. Circulation 2005; 112:2735–2752.
2. Straker D, Corell CU, Kramer-Ginsberg E, Abdulhamid N, Koshy F, Rubens E, Saint-Vil R, Kane JM, Manu P: Cost-Effective screening for the metabolic syndrome in patients treated with second-generation antipsychotic medications. Am J Psychiatry 2005; 2:1217–1221.

Poster 103 **Friday, October 12 3:00 p.m.-4:30 p.m.**

BENCHMARKING PSYCHIATRIC INTENSIVE CARE UNITS (PICU) IN AMSTERDAM

Cecilia Gijsbers van Wijk, M.D., *Psychiatrist, Research Department, Jellinek Mentrum, 2e C. Huygenstraat 37–39, Amsterdam, Netherlands*

SUMMARY:

Background: The use of psychoactive substances to self-medicate is not well documented in the general population.

Objectives: To estimate the type and frequency of healthcare and substance use to cope with anxiety disorders or depressive episodes, and to determine factors associated with this substance use, taking health care use into account.

Methods: Data from a survey of the French general population (n=20, 077) were used. Mental episodes were determined using the CIDI-SF and subjects were asked if they had used substances and mental health care to cope with these episodes.

Results: The use of substances to self medicate was 17.4 % among men and 7.1 % among women. Mostly, subjects who used substances also used health care. Men, single persons and the young were more likely to use substances. The likelihood of using substances and health care was increased when subjects suffered from severe disability.

Discussion: This study is of interest in helping to prevent substance use disorders, by defining two targets according to health care use.

REFERENCES:

1. Bolton, J., Cox, B., Clara, I., et.al (2006) Use of alcohol and drugs to self-medicate anxiety disorders in a nationally representative sample. J Nerv Ment Dis, 194, 818–825.
2. Mueser, K. T., Drake, R. E., Wallach, M. A. (1998) Dual diagnosis: a review of etiological theories. Addict Behav, 23, 717–734.

Poster 104 **Friday, October 12 3:00 p.m.-4:30 p.m.**

AN INNOVATIVE MODEL FOR THE MANAGEMENT OF OBSTRUCTIVE SLEEP APNEA IN PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Cheryl Graber, M.D., *Resident, Department of Psychiatry, University of Medicine and Dentistry of New Jersey, 671 Hoes Lane, Room C-205, Piscataway, NJ 08854*; Anthony M. Tobia, M.D.; Anita Mallya, M.D.; Matthew Macaluso, D.O.; Mark Miceli, M.D.

SUMMARY:

Objective: To study the impact of specialized medication groups on the physical health status of individuals with severe and persistent mental illness (SPMI) and co-occurring obstructive sleep apnea (OSA) attending a partial hospital program.

Methods: At the Extended Partial Hospital program in Monmouth Junction, 15 schizophrenic patients with co-occurring OSA took part in this pilot study to test if participation in a group comprised of patients with similar medical illness resulted in more efficient coordination of care and improvement in physical health status. Baseline data were recorded, and at 12 months, follow-up data were collected on all patients to evaluate the impact of this specialized medication group on the identified parameters.

Results: After 12 months of participating in specialized medication groups, patients were found to have greater knowledge of their medical illness and improved global functioning. Their clinical psychiatric stability was unaffected or improved as measured by clinicians' rating scales. The impact of nursing and case management resulted in more efficient coordination of care with primary providers.

Conclusions: Assignment of mentally ill patients to medication groups according to their physical illness is a unique and efficient model lending to improved quality of care, patient satisfaction and overall wellbeing.

REFERENCES:

1. Yaggi, HK, et.al.: Obstructive Sleep Apnea as a Risk Factor for Stroke and Death. N Eng J Med 2005; 353(19): 2034–2041.
2. Young T, Skatrud J, Peppard PE: Risk factors for obstructive sleep apnea in adults. JAMA 2004; 291: 2013–20.

Poster 105 **Friday, October 12 3:00 p.m.-4:30 p.m.**

COLLEGE MENTAL HEALTH: A QUALITATIVE STUDY OF COUNSELING CENTER SERVICES IN THE SOUTH AND MIDWEST

Justin B. Hunt, M.D., *Fellow, Robert Wood Johnson Scholars Program, University of Michigan Medical School, 2917 North Kingsbridge Circle, Ann Arbor, MI 48105*; Geoff Curran, Ph.D.; J. Greer Sullivan, M.D.; Ed Deneke, M.D.

SUMMARY:

Background: Recent research shows that the incidence of mental health and substance abuse problems are increasing among persons attending colleges (Gallagher et.al., 2004; Pledge et.al., 1998; O'Malley et.al., 1990). There is also report of an increased need for services without a corresponding increase in funding (Gallagher et.al., 2004). Currently, we simply do not know what specific factors are leading to this recent increase in psychiatric morbidity on campuses. Whatever the cause of this increasing burden of mental illness, it is clear that further research is indicated and meeting these students' needs must be a focus for university administrators funding the counseling services.

Specific Aims: The specific aims of this qualitative, key informant interview study are to explore: 1.) Possible underlying medical, psychological, social, and cultural reasons for the development of severe psychopathology among students at each studied university or college; 2.) Patient characteristics and volumes present in the studied college counseling centers; 3.) Administrative structure and funding of the studied college counseling centers; and 4.) Barriers and facilitators in responding to increased patient volume.

Methods: The PI uses the qualitative, key informant interview approach to collect data from 10 college counseling directors. Purposive sampling has been used in participant selection to obtain a diverse representation of both predominantly black and white institutions and also of undergraduate liberal arts colleges, national PhD-granting universities, and more regional state public institutions. Only counseling center directors at universities and colleges in Arkansas, Illinois, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas have been invited to participate.

Preliminary Findings: In addition to the above delineated information, the poster will also contain my preliminary findings which include specific coded quotations from the ten interviews with college counseling center directors. The quotes address the issues mentioned in the specific aims section above.

REFERENCES:

1. Gallagher, R., Zhang, B., & Taylor, R. (2004). National survey of counseling center directors. Retrieved February 17, 2006, from Web site: http://iacsinc.org/2004%20Survey%20final-1.pdf.
2. American College Health Association. (2002). National College Health Assessment: Reference Group Report. Baltimore, MD: American College Health Association.

Poster 106 **Friday, October 12 3:00 p.m.-4:30 p.m.**

GUIDANCE COUNSELORS' ATTITUDE OF HIGH SCHOOL STUDENTS MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES

Gabriella Inczedy Farkas, *Graduate Medical Student, Medical Faculty, Semmelweis University, 36 Street Frankel Leo, Budapest, Hungary 1023*; Carl D. Hanson, M.D., *Medical Director, SBS Consulting, 65 School Street, Acton, MA 07204*

SUMMARY:

Objective: Our qualitative study examines guidance counselors' attitudes and typical practices regarding students' mental health and substance abuse in three different kind of high schools.

Method: Information was obtained via semi-structured interviews with school representatives.

Result: The largest school has the most effective system suggesting that with bigger size goes a higher degree of preparedness to handle occurring problems. Although in smaller schools there is a higher possibility to be in personal contact with counselors and teachers, school staffs in these schools don't feel being able to make considerable impact on students' choices.

Conclusions: School's health care staffs – regardless of the institute's size and methodology - while keeping personal and confident contact with the students ought to implement an elaborate system in order to effectively address occurring problems.

REFERENCES:

1. Manson SM, Beals J, Dick RW, Duclos C. Risk factors for suicide among Indian adolescents at a boarding school. Public Health Reports. 104(6):609–14, 1989 Nov-Dec.
2. Anglin TM, Naylor KE, Kaplan DW. Comprehensive school-based health care: high school students' use of medical, mental health, and substance abuse services; Pediatrics; 97(3):318–30, 1996 Mar.

Poster 107 **Friday, October 12 3:00 p.m.-4:30 p.m.**

KINETICS OF GLUTAMATE DEHYDROGENASE ACTIVITY IN LEUKOCYTES OF ALCOHOLICS

Matej Kravos, M.D., Ph.D., *Psychiatrist, Department of Psychiatry, Psychiatric Hospital Ormoz, Maistrova 13, Maribor, Slovenia 2000*; Ivan Malesic, Ph.D.

SUMMARY:

Alcoholism has a pronounced effect on people's mental and physical health. Glutamate dehydrogenase (GLDH) is a linking factor in metabolism of carbohydrates and proteins. GLDH is an enzyme of mitochondrial matrix, but the latest data reveal it is also found in rough endoplasmic reticulum. Endoplasmic reticulum acts as the central hub for the protein – producing cellular machinery. There is few relevant data about the role of GLDH in leukocytes and the effect of alcohol on leukocytes so far.

The aim of our study was to define GLDH activity in leukocytes under and after alcohol consumption, what can give us indirect data about protein metabolism in leukocytes.

We developed our own method to define GLDH activity and established our own reference activities for GLDH in leukocytes which were from 0.05–1.17 μkat/g protein.

Our research has been done on 142 healthy subjects and 113 alcoholics, aged from 18 to 65, having consumed alcohol within last 48 hours. Mean catalytic activity in healthy subjects was 0.5649 ?kat/g protein. Mean catalytic GLDH activity in alcoholics increased from 0.5042 ?kat/g to 0.6696 ?kat/g after 24–48 hours to 0.6974 ?kat/g after 48–72 hours of abstinence. Using nonparametric Mann-Whitney U Test we found a statistically significant increase ($Z = -2.500$, $p = 0.012$) in GLDH activity after 48–72 hours of abstinence. It is possible to conclude that under the influence of alcohol the leukocyte GLDH activity in alcoholics is lower than in healthy subjects. Cessation of alcohol consumption has resulted in a statistically significant increase in leukocytes GDLH activity. Therefore, alcohol consumption results in reduction in GLDH activity, as well as protein production and consecutively leads to diminished leukocytes protective ability.

REFERENCES:

1. Woo-kyoung L, Seungjin S, Soo Soeck C, Jongsang P: Purification and characterization of glutamate dehydrogenase as another isoprotein binding to the membrane of rough endoplasmatic reticulum. J Cell Biochem 1999; 76:244–253.
2. Beutler E: Composition and metabolism of neutrophils. In Williams Hematology. 6th ed., edited by Beutler E, Lichtman MA, Coller BS, Kipps TJ, Seligsohn U, New York, McGraw-Hill companies, 2005, 745–752.

Poster 108 **Friday, October 12 3:00 p.m.-4:30 p.m.**

REDUCING POST-TRAUMATIC STRESS AFTER HURRICANE KATRINA: A SCHOOL-BASED INTERVENTION

Leslie E. Lawrence, M.D., *Associate Clinical Professor, Department of Psychiatry and Neurology, Tulane University Medical Center, 1440 Canal Street, # TB-53, New Orleans, LA 70112-2703*; Adrienne Mishkin, B.A.; Mark J. Viron, M.D.; Janet Johnson, M.D.

SUMMARY:

Objective: To determine the prevalence of post-traumatic stress symptoms (PTSS) among the children of a middle school in post-Katrina New Orleans and to evaluate the effect of a guided-workbook intervention on these symptoms.

Method: During September 2006, the UCLA Child PTSD Reaction Index (PTSD-RI) was administered to the 149 5th–8th graders of McDonogh 15, a school consisting primarily of socioeconomically disadvantaged African-Americans, all of whom had experienced Hurricane Katrina in some way. After initial assessment, the students were given the option of 30 minutes of class time per week for two months to work independently on a guided activity workbook designed for children exposed to the storm. After two months, the 117 children who utilized the workbook were reassessed with the PTSD-RI.

Results: Before the workbook, the median RI score was 24, and 54 students (46%) displayed moderate to severe PTSS. Post-workbook, 43 students (37%) displayed moderate to severe PTSS, and the median RI score decreased by 17% to 20 ($p=.0096$).

Summary: Similar to previously reported findings, the use of a guided workbook may be a simple and effective intervention to reduce post-traumatic stress in children

exposed to hurricanes. Numerous confounders need to be considered.

REFERENCES:

1. Pynoos R, Rodriguez N, Steinberg A, Stuber M, Frederick C: The UCLA PTSD Reaction Index for *DSM-IV* (Revision 1). Los Angeles, UCLA Trauma Psychiatry Program, 1998.
2. Kliman G, Oklan E, Wolfe H, Kliman J: My Personal Story about Hurricanes Katrina and Rita: A Guided Activity Workbook for Middle and High School Students. San Francisco, The Children's Psychological Health Center, 2005.

Poster 109 **Friday, October 12 3:00 p.m.-4:30 p.m.**

EFFICACY OF ACAMPROSATE IN ENHANCING TOTAL AND CONTROLLED ABSTINENCE: A META-ANALYSIS

Supported by Forest Laboratories, Inc.

Philippe Lehert, Ph.D., *Faculty of Economics, Department of Statistics, Louvain Academy, Chausse de Binche, 151, Mons, Belgium 7000*; Stavros Tourkodimitris, Ph.D.; Frederic Landron, M.D.

SUMMARY:

Introduction: Several recent trials of alcohol dependence have indicated the clinical importance of controlled abstinence (CA). In addition to confirming the effect of acamprosate on total abstinence (TA), this meta-analysis assesses its effect on CA.

Methods: Twenty-three randomized, placebo-controlled trials (RCT) of acamprosate were selected according to predetermined criteria. Seven were excluded for lack of comparable abstinence measures, adequate control, or unpublished patient data. Primary outcome measures were TA (0 drinks/day, reported in published studies) and CA (<5 drinks/day, documented in unpublished data). Clinical relevance was estimated using conventional meta-analytical techniques, as well as a generalized linear mixed model. Estimated treatment effects included: overall risk difference (RD), relative benefit, and odds ratio.

Results: Sixteen RCTs (N=4457) were included. Unadjusted TA percentages at study endpoint were 25.8% for acamprosate vs. 17.8% for placebo. Treatment effects were consistently favorable for acamprosate over placebo. According to the 2 statistical models, RD estimates for TA were 11.1% [95% CI, 6.9–15.0] and 9.3% [95% CI, 7.0–11.7]; estimates for CA were 13.5% [95% CI, 9.1–17.9] and 11.9% [95% CI, 9.0–14.6]. Treatment effects in each statistical model were significant (P<.001).

Conslusion: In addition to maintaining total abstinence, acamprosate provides a significant benefit by reducing alcohol consumption.

REFERENCES:

1. Pelc I, Verbanck P, Le Bon O, Gavrilovic M, Lion K, Lehert P: Efficacy and safety of acamprosate in the treatment of detoxified alcohol-dependent patients. A 90-day placebo-controlled dose-finding study. Br J Psychiatry. 1997;171:73–77.
2. Sass H, Soyka M, Mann K, Zieglgansberger W: Relapse prevention by acamprosate. Results from a placebo-controlled study on alcohol dependence. Arch Gen Psychiatry. 1996;53:673–680.

Poster 110 **Friday, October 12 3:00 p.m.-4:30 p.m.**

AN INNOVATIVE MODEL TO IMPROVE QUALITY OF CARE IN THE SEVERELY AND PERSISTENTLY MENTALLY ILL

Matthew Macaluso, D.O., *Resident, Department of Psychiatry, University of Medicine and Dentistry of New Jersey, 671 Hoes Lane Room C-205, Piscataway, NJ 08854*; Anthony M. Tobia, M.D.; Cheryl Graber, M.D.; Gagandeep R. Singh, M.D.; Saranga Shah, D.O.

SUMMARY:

Introduction: Hepatitis C virus infection affects more than 4 million people in the U.S. Patients with severe and persistent mental illness (SPMI) experience significant morbidity and early mortality due to medical causes. Addressing the physical health of patients with SPMI is a unique challenge to physicians who care for this special population.

Methods: At our Extended Partial Hospital program, 7 schizophrenic patients with co-morbid hepatitis C infection took part in this pilot study to test if a group comprised of patients with similar medical illness resulted in more efficient coordination of care, and improvement in physical health status. Baseline data were recorded, and at 6 months, data were collected on all patients to evaluate the impact of these specialized medication groups.

Results: Patients participating in medication groups were found to have greater knowledge of their illness and improved global functioning. Their clinical stability was unaffected or improved as measured by clinicians' rating scales. The impact of nursing and case management resulted in more efficient coordination of care with primary providers.

Conclusions: Assignment of mentally ill patients to medication groups by their physical illness is a unique

and efficient model lending to improved quality of care, patient satisfaction and overall wellbeing.

REFERENCES:

1. Centers for Disease Control and Prevention. Recommendations for prevention and control of hepatitis C virus infection and HCV-related chronic disease. MMWR Recomm Rep. 1998; 47: 1–39.
2. American Gastroenterological Association Medical Position Statement on the Evaluation and Treatment of Viral Hepatitis, 2004.

Poster 111 **Friday, October 12 3:00 p.m.-4:30 p.m.**

"AS A MAN THINKETH SO IS HE": A QUALITATIVE ANALYSIS OF CHRISTIAN CLERGY'S PORTRAYAL OF MENTAL ILLNESS IN TELEVISED SERMONS

Rhonda J. Mattox, M.D., *Division of Psychiatry and Behavioral Health, University of Arkansas Medical Sciences, 2220 Fort Root Drive, Building 58, Slot 152 NLR, North Little Rock, AR 72114*; Jennifer R. Ivory, M.P.H.; J. Greer Sullivan, M.D.; Jean McSweeney, Ph.D.; Kelly C. Hair, M.D.

SUMMARY:

Significance: Mental illnesses (MI) are the leading causes of disability in America. Although safe, effective treatments are available to treat MI, many delay or fail to seek medical treatment. Depression alone is estimated to cost more than $66 billion/year. Investigations have consistently revealed that individuals suffering with symptoms of MI are more likely to consult a religious leader than a clinician. Yet, little is known about what clergy are saying about mental illness.

Objective: Describe clergys' portrayal of MI in televised sermons.

Methods: 300 televised sermons were videotaped over 3 months. 90 were randomly screened. Sermons containing references to mental health (35) were transcribed and entered into Ethnograph. Coders reviewed sermons and developed a codebook that a qualitative methodology expert reviewed/revised. Analysis was based on ethnographic derived approach.

Results: References to MI were absent. References to emotional symptoms, health, and hygiene were present. The cognitive behavioral model of depression and anxiety was prominent. The biomedical or neurochemical model was absent. Anxiety symptoms were frequently perceived to be inversely related to spiritual proximity to God/faith and directly related to influence of demonic influences. Depressive symptoms were frequently attributed as controllable via thoughts, attitudes, beliefs, or knowledge.

REFERENCES:

1. Atdjian S, Vega WA: Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. Psychiatric Services 56(12):00–02, 2005.
2. Wang PS, Berglund PA, Kessler RC: Patterns and correlates of contacting clergy for mental disorders in the United States. Health Services Research 38(2):647–673, 2003.

Poster 112 **Friday, October 12 3:00 p.m.-4:30 p.m.**

APPLYING EVIDENCE-BASED MEDICINE TO PRESCRIBING PRACTICES IN COMMUNITY MENTAL HEALTH CENTERS

Supported by Comprehensive NeuroScience, Inc.

Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; George Oestricht, Pharm.D.; Harold Carmel, M.D.; Paul Stuve, Ph.D.

SUMMARY:

Applying evidence-based medicine to normal community psychiatrist prescribing practices has proven extremely difficult. Full-time practicing psychiatrists do not have the time to consult with literature reports or practice guidelines on a regular basis for individual patients. In addition, there is extremely limited information as to the actual range within the standard of practice for specific prescribing decisions and no information available to the prescriber or Community Mental Health Center regarding where they fall within that range. This poster reports on an innovative disease management, quality improvement approach based on Comprehensive Neuroscience Inc., quality indicators for psychiatric prescribing. Evidence-based prescribing information is provided on specific individual patients regarding individual specific prescribing decision points. Both individual prescribers and CMHC group prescribing practices are provided with reports benchmarking the degree to which their overall prescribing compares to their peers. This poster reports on the range of practice across individual prescribers and CMHC group prescribing practices serving similar patient groups. This approach shows a greater impact on prescribing practice compared to quality improvement approaches only involving the individual prescriber and not the organizations within which they practice.

REFERENCES:

1. Using Best Practices to Manage Psychiatric Medications Under Medicaid with Richard Surles, Ph.D., Psychiatric Services, Vol. 55 No. 11, November 2004, pp 1227–1229.
2. Missouri's Experiment to Increase Quality – and Decrease Costs, with George Oestreich and Richard Surles Behavioral Healthcare, February 2006, Volume 26, Number 2, pp 12–37.

Poster 113 **Friday, October 12 3:00 p.m.-4:30 p.m.**

SCHIZOPHRENIA COLLABORATIVE RESOURCE (SCORE) TOOL: TRACKING PATIENT PROGRESS

John P. Docherty, M.D., *Chief Executive Officer and President, Comprehensive Neuroscience, Inc., and Adjunct Professor of Psychiatry, Weill Medical College, Cornell University, 21 Bloomingdale Road, White Plains, NY 10605*; Cynthia A. Bossie, Ph.D.; Stephen Rodriquez, M.S.; Mary J. Kujawa, M.D., Ph.D.; Robert Conley, M.D.; Stephen R. Marder, M.D.

SUMMARY:

Objective: To describe a unique software program for optimizing patient care throughout the course of schizophrenia by identifying the stage of illness, creating a personalized patient profile and treatment goals, and tracking these over time.

Methods: Clinicians, expert in treating patients with schizophrenia, conducted extensive literature reviews and analyzed clinical data from acute, stable, and remitted patients to describe stages of illness and associated symptom severity and level of functioning.

Results: A software tool designed to capture information about the status of patients with schizophrenia has been developed. This interactive program consists of an algorithm that captures information (from both clinician and patient) on current interventions, symptom severity, social functioning, stress tolerance, cognition, and physical health domains. The patient's illness is staged according to the level and type of clinical intervention and the severity of symptoms. At subsequent visits these inputs are re-evaluated, and improvements or setbacks are measured to determine the patient's stage. These data can then be used to develop treatment goals and to track patient progress over time.

Conclusions: This tool provides physicians and patients with a common point of reference in the tracking and management of schizophrenia.

REFERENCES:

1. Andreasen NC, Carpenter WT Jr, Kane JM, et.al: remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry 2005;2:441–449.
2. van Os J, Drukker M, A Campo J, et.al: Validation of remission criteria for schizophrenia. Am J Psychiatry 2006;3:2000–2002.

Poster 114 **Friday, October 12 3:00 p.m.-4:30 p.m.**

COMPARISON OF ASSERTIVE COMMUNITY TREATMENT PROGRAMS IN INNER URBAN AND RURAL TEAMS IN NORTH CAROLINA AND MASSACHUSETTS

Dan J. Siskind, M.D., M.P.H., *Visiting Scientist, Program in Health Decision Science, Harvard School of Public Health, 718 Huntington Avenue, Suite 2, Boston, MA 02139*; Elizabeth Wiley-Exley, M.P.H.

SUMMARY:

Background: Assertive Community Treatment (ACT) is a service delivery model designed to provide an integrated approach to care for the severally mentally ill. Strict guidelines on service provision have been developed, and fidelity scales created to determine how closely ACT programs align with these guidelines. Despite this standardization, ACT teams often have to adapt as available resources and the communities they serve may differ greatly.

Aims: We compared ACT teams in inner urban regions of Boston, MA and rural areas of North Carolina, looking at patient and team characteristics and regional demographics. With a better understanding of these individual and programmatic characteristics in different global regions, we can gain a greater understanding of the adaptability of the ACT model.

Methods: We analysed and compared data on: 1.) Patient characteristics - diagnosis, ethnicity, education, hospital days, medication use, comorbities and social functioning; 2.) Demographics of the two regions - catchment population, employment rates, homelessness, involvement in criminal justice system, ethnic mix, average income, and age; and 3.) Team characteristics - patient load, staff turnover rate, psychiatrist hours, number of weekly contacts and patient turnover.

Results: The ACT teams surveyed had adapted to serve their patient populations. Although most met fidelity criteria, they differed in aspects of patient and team characteristics, reflecting the underlying demographics and challenges of the different regions.

Conclusions: The ACT model is now used nationally, and has adapted to suit the environments in which it operates. A better understanding of these individual and programmatic characteristics will assist in more specific

work on ACT teams serving these diverse and challenging populations. In addition, the differences between the teams may suggest a need for more flexibility in state and Federal policies regarding ACT.

REFERENCES:

1. Meyer, P. S. and J. P. Morrissey (2007). A comparison of assertive community treatment and intensive case management for patients in rural areas. Psychiatr Serv 58(1): 121–7.
2. Teague, G. B., G. R. Bond, et.al. (1998). Program fidelity in assertive community treatment: development and use of a measure. Am J Orthopsychiatry 68(2): 2–32.

Poster 115 **Friday, October 12 3:00 p.m.-4:30 p.m.**

AN INTERVENTION TO PROMOTE EVIDENCE-BASED PRESCRIBING: LOW-DOSE QUETIAPINE

Keith R. Stowell, M.D., M.S., *Resident, Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Frank Ghinassi, Ph.D.; Roger F. Haskett, M.D.; Tanya Fabian, Ph.D.; Karen Fielding, Pharm.D.; Kristen Sakely, R.Ph.

SUMMARY:

Objective/Background: Current research does not provide an empirical basis for the prescription of low-dose second generation antipsychotics to treat insomnia and anxiety. The literature suggests no improvement in the quality of patient care with such prescriptions, yet this practice has led to substantial increases in the cost of treatment. The purpose of this study was to increase physician awareness of these prescribing practices and to develop a system for discussion of alternative treatments.

Methods: New inpatient prescriptions of low-dose quetiapine at Western Psychiatric Institute and Clinic were monitored for 18 months. Pertinent information on such prescriptions was collected by the hospital pharmacy. Electronic summary reports were e-mailed to the Unit Medical Director who subsequently contacted the prescriber to determine the indication for the medication.

Results: At the start of the study in July 2005, new prescriptions for low-dose quetiapine totaled 107. An overall decline in prescriptions occurred over the course of the subsequent months, with only 23 such prescriptions in the final month of the study. Overall cost savings averaged $5,000 per month.

Conclusions: These findings indicate that a minimal intervention was able to reduce prescribing practices that are not empirically based, improving patient care and resulting in considerable cost reductions.

REFERENCES:

1. Soumerai SB, Avorn J. Principles of educational outreach (''academic detailing'') to improve clinical decision making. JAMA. 1990;263:549–556.
2. Wysowski DK, Governale LA, Swann J. Trends in outpatient prescription drug use and related costs in the U.S.: 1998–2003. Pharmacoeconomics. 2006;24: 233–6.

Poster 116 **Friday, October 12 3:00 p.m.-4:30 p.m.**

USE OF THE PCL FOR ESTIMATING PTSD PREVALENCE IN VARIOUS POPULATIONS: DEFINING OPTIMAL CUTOFF CRITERIA FOR POPULATION STUDIES

Artin Terhakopian, M.D., *Psychiatrist, U.S. Army, Uniformed Services University of the Health Sciences, 4301 Jones Bridges Road, Bethesda, MD 20814*; Charles Hoge, M.D.; Charles Engel, M.D.; Ninet Sinaii, Ph.D.; Paula Schnurr, Ph.D.

SUMMARY:

Post-Traumatic Stress Disorder (PTSD) is a common condition among combat veterans, and other survivors of traumatic experiences. The PTSD Checklist (PCL) is one of the instruments most often used to assess PTSD, whether for estimating prevalence in a study population, clinical screening in primary care or mental health settings, or measuring symptom severity. An analysis of published sensitivity and specificity data associated with different PCL cutoffs has not been reported previously. We combined data from published studies where the PCL was compared with structured diagnostic interviews (CIDI, SCID, CAPS). Weighted sensitivities and specificities were calculated for the different PCL cutoffs most often reported in the literature. The weighted sensitivity from the pooled studies decreased from 0.87 to 0.28 and the weighted specificity increased from 0.69 to 0.97 over a range of PCL cutoffs between 30 and 60. In study populations where the true prevalence of PTSD is 15% or less, PCL cutoffs of less than 44 will significantly overestimate the population prevalence. In contrast, in clinical populations where the prevalence is greater than 15% and purpose of using the PCL is finding of most clinical cases, lower cutoff scores may be necessary.

REFERENCES:

1. Weathers FW, Litz BT, Herman, DS, Huska JA, Keane TM. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility.

Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies.
2. Kessler R. C., Sonnega A, Bromet E, Hughes M, & Nelson CB. (1995). Post-Traumatic Stress Disorder in the National Comorbidity Survey. Arch Gen Psychiatry, 52(12), 1048–1060.

POSTER SESSION 5

Posters 117–145
Saturday, October 13

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

BIOLOGICAL PSYCHIATRY AND PHARMACOLOGY: PART II

Poster 117 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

ENCEPHALITIS LETHARGICA: A CASE STUDY AND LITERATURE REVIEW

Farha Z. Abbasi, M.D., *Resident, Department of Psychiatry, Michigan State University, A233-East Fee Hall, East Lansing, MI 1316*

SUMMARY:

Introduction: In 1917, Dr. von Economo described Encephalitis lethargica, a CNS disorder thought to be related to Spanish flu, presenting as sleep disorders, basal ganglia disturbances and neuropsychiatric sequelae, leaving victims like living statues. It became an epidemic between 1900–1927 killing aproximately 5 million people. Since then the fatal appearances of this disease have been rare and sporadic.

Objective: The purpose of the present paper is to examine the neuropsychiatric sequelae of a single case of post-viral encephalitis.

Method: A 23 year old woman initially admitted with possible viral meningitis and treated with rocephin and steroids started showing cognitive impairment, psychosis, fever, dyskinesias of tongue and limbs, mutism, and catatonia. Her CSF showed lymphocytosis and elevated proteins. Her brain CT scan was negative, and her EEG revealed generalized slowing. Her viral panel and fungal panel were negative, and her brain MRI was unremarkable. The Rancho Los Amigos Cognitive Scale was level IV, and the Glasgow Coma Score was 14. The patient was subsequently referred to a neuropsychiatric rehabilitation program.

Results: After all other possible causes of encephalitis were ruled out the diagnosis of encephalitis lethargica was confirmed. The possibility of post viral or post streptococcal immune injury was considered. The patient subsequently recovered after aggressive treatment with steroids, antibiotics, and antipsychotics. Her cognitive functions are improving with some residual memory loss and mood lability following outpatient rehabilitation.

Conclusion: The literature suggests that encephalitis lethargica, which has a predilection for midbrain and basal ganglia, may have delayed development of mood disorders and Parkisonism. This case appears to exemplify this association.

REFERENCES:

1. Vincent Angela, EL:Part of a spectrum of post-streptococcal autoimmune disease? Brain, 2004; Vol. 127;(1):2–3.
2. Dale RC et.al., EL Syndrome:20 new cases and evidence of basal ganglia autoimmunity, 2004; Brain; Vol.127(1):21–33.

Poster 118 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

CONVERSION GUIDELINES IN SWITCHING FROM DEPAKOTE DELAYED-RELEASE TO DEPAKOTE EXETENDED-RELEASE IN THE ELDERLY: A PILOT STUDY

Supported by Abbott Laboratories

Vadim Y. Baram, M.D., *Clinical Instructor, Department of Psychiatry, St. Louis University, 12 Tristan Terrace, St. Charles, MO 63303*

SUMMARY:

Background: Divalproex sodium extended release (ER) tablets (Depakote ER®), formulated in a hydrophilic polymer matrix, has a functional half life of > 27 hours in adults and can be given once a day vs. the usual 2–3 times per day with divalproex sodium delayed release (DR) tablets (Depakote DR®). This should improve compliance. A slower, more steady rise to Cmax with the ER formulation may also moderate side effects and improve tolerability, especially in the elderly, who are more sensitive to side effects.

Methods: The purpose of this research project was to assess the tolerability and safety of Depakote ER in older adults who were being converted from divalproex DR to divalproex ER, as well as to develop conversion guidelines. Six older adults (2 male and 4 female, mean age = 77 years) were studied in detail, including monitoring of valproic acid serum levels and side effects. All patients were clinically stable on divalproex DR at the time of conversion. Clinical Global Impression (CGI) was used to assess any change in clinical response.

Results: Overall, all 6 patients were successfully converted from divalproex DR to ER. Mean CGI scores showed no change in the patients' clinical response to

divalproex following the conversion (3.5 and 3.7 at weeks 1 and 4, respectively; p >0.05 vs. a score of 4, reflecting no change from baseline). The most common side effects at study entry included somnolence, ataxia (4 patients each), dizziness, and malaise (3 patients each). After conversion to divalproex ER, a trend toward better tolerability was observed: At week 4, fewer patients reported ataxia, dizziness, malaise, weakness, and nausea, and more patients reported appetite change and dyspepsia. Valproic acid serum level correlates were useful in defining dosing equivalence of divalproex DR vs. ER: Mean level was 55.8 mcg/ml at baseline and 77.3 and 79.8 mcg/ml at weeks 1 and 4 after conversion, respectively.

Conclusions: This is the first study to examine the conversion from divalproex DR to ER in the elderly with serum level monitoring as a guideline to conversion. With mounting concerns relative to the safety of atypical antipsychotics in demented elders, clinicians are often turning to alternative approaches including the use of anticonvulsants such as divalproex ER.

REFERENCES:

1. Hardy BG, Shulman KI, Mackenzie SE, Kutcher SP, Silverberg JD. Pharmacokinetics of lithium in the elderly. J Clin Psychopharmacol 1987;7:153–8.
2. Tueth MJ, Murphy TK, Evans DL. Special considerations: use of lithium in children, adolescents, and elderly populations. J Clin Psych 1998;59 (suppl 6):66–72.

Poster 119 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

PHARMACOKINETIC (PK) PHARMACODYNAMIC (PD) RELATIONSHIP FOR ILOPERIDONE

Supported by Vanda Pharmaceuticals, Inc.

Paolo Baroldi, M.D., Ph.D., *Chief Medical Officer, Vanda Pharmaceuticals, Inc., 9605 Medical Center Drive, Suite 300, Rockville, MD 20850*; Curt Wolfgang, Ph.D.; Dennis Fisher, M.D.

SUMMARY:

Introduction: Iloperidone is a mixed D2/5-HT2 antagonist antipsychotic (1,2). We investigated the exposure-response relationship for iloperidone through PK-PD modeling analysis.

Methods: During two phase 3 trials, iloperidone plasma levels were obtained at steady state. Trial data were combined with those of a previous PK study, which found that the PK of iloperidone was dose linear, to build a population PK model. Cavg = 0 was assigned to placebo-treated patients as baseline for comparison. After modeling, predicted or simulated values of Cavg at last steady state dose were made and correlated with last available efficacy measurements using multiple regression analysis.

Results: Schizophrenia symptom improvement was associated with higher iloperidone Cavg after baseline adjustment (study drug ranges, 12–24 mg/d). Statistically significantly greater proportions of responders (= 20% improvement from baseline) in iloperidone treated patients had Cavg =5 ng/mL compared with those with Cavg <5 ng/mL for 4 out of 5 efficacy scales (P < .05) (Positive and Negative Syndrome Scale [PANSS] total, PANSS positive, PANSS general psychopathology, and Brief Psychiatric Rating Scale [BPRS]).

Conclusions: Iloperidone showed an exposure-response relationship, suggesting that the minimal effective exposure level for iloperidone is 5 ng/mL. Therapy with iloperidone may be individualized through consideration of this PK-PD relationship.

REFERENCES:

1. Kalkman HO, Subramanian N, Hoyer D: Extended radioligand binding profile of iloperidone: A broad spectrum dopamine/serotonin/norepinephrine receptor antagonist for the management of psychotic disorders. Neuropsychopharmacol 2001;25:904–914.
2. Kalkman HO, Feuerbach D, Lotscher E, Schoeffter P. Functional characterization of the novel antipsychotic iloperidone at human D2, D3, 5-HT6, and 5-HT1A receptors. Life Sciences 2003;3:1151–1159.

Poster 120 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

CONSEQUENCES OF PATIENT REPORTED MEDICATION SATISFACTION WITH SECOND GENERATION ANTIPSYCHOTICS IN BIPOLAR DISORDER

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Jay Bates, Ph.D., *Manager, Outcomes Research, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Plainsboro, NJ 08536-1615*; Edward Kim, M.D.; W. Robert Simons, Ph.D.; Richard Whitehead, B.S.

SUMMARY:

Objective: To assess the effects of self-reported satisfaction with second-generation antipsychotics (SGAs) on adherence and clinical outcomes in bipolar disorder.

Methods: We analyzed data from the National Health and Wellness Survey (NHWS). Data from a subset of patients with bipolar disorder treated with an SGA plus mood stabilizer were analyzed. Logistic regression as-

sessed the relationship between satisfaction (5-point Likert scale) and medication adherence, and the relationship between non-adherence and episodes of depression or mania. Overall satisfaction with aripiprazole was compared to that of other SGAs using a MANOVA with an adjusted Tukey test.

Results: Of the 1,785 bipolar patients (43% male with a mean age of 41±13.5 years), 384 met full inclusion criteria. Low satisfaction was significantly associated with medication non-adherence (p=0.006), which was associated with significantly increased risk of depressive (Relative Risk [RR] 1.70; p=0.03) and manic (RR 1.71; p=0.02) episodes. With an adjusted-critical value after adjusting Tukey for multiple testing (p=0.0125), results indicate that fewer aripiprazole patients are dissatisfied with their prescribed medication than olanzapine (p= 0.010).

Conclusion: Low satisfaction with SGAs is associated with reduced medication adherence in patients with bipolar disorder. Patients treated with olanzapine were significantly less satisfied than those treated with aripiprazole.

REFERENCES:

1. Fleck DE, Keck PE Jr, Corey KB, Strakowski SM. Factors associated with medication adherence in African American and white patients with bipolar disorder. J Clin Psychiatry 2005; 66:646–652.
2. Keck PE, McElroy SL, Strakowski SM, Balistreri TM, Kizer DI, West SA. Factors associated with maintenance antipsychotic treatment of patients with bipolar disorder. J Clin Psychiatry 1996; 57:147–151.

Poster 121 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

ARIPIPRAZOLE AS ADJUNCTIVE THERAPY IN MAJOR DEPRESSIVE DISORDER: STUDY CN138-139

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Bhrett McCabe, Ph.D., *Medical Science Manager, Clinical Neurosciences Research Centre, Bristol-Myers Squibb Company, 1040 Greystone Cove, Hoover, AL 35242*; Robert M. Berman, M.D.; Ronald N. Marcus, M.D.; Rene Swanink, M.S.; William Carson Jr., M.D.; Robert D. McQuade, Ph.D.; Arif M. Khan, M.D.

SUMMARY:

Objective: Evaluate the efficacy and safety of adjunctive aripiprazole versus placebo to standard antidepressant therapy (ADT) in patients with major depressive disorder (MDD) who showed an incomplete response to =1 historical ADT and one prospective ADT.

Methods: A 7- to 28-day screening phase, an 8-week, prospective treatment phase and a 6-week randomization phase. During prospective treatment, patients experiencing a major depressive episode received ADT. Incomplete responders were randomized to continued adjunctive placebo or aripiprazole (2–20 mg/day). The primary efficacy endpoint was mean change in MADRS Total score from end of prospective treatment to end of randomized treatment (Week 14, LOCF).

Results: Baseline demographics were similar between the adjunctive placebo (n=178) and aripiprazole (n=184) groups. Mean MADRS change was significantly greater with adjunctive aripiprazole versus placebo (–8.8 vs. –5.8; p<0.001). Adverse events in equal or greater than 10% of patients with either adjunctive placebo or aripiprazole were: akathisia; headache; restlessness. Incidence of adverse events leading to discontinuation was low in patients treated with adjunctive placebo (1.7%) and aripiprazole (2.2%). Weight gain equal or greater than 7% was seen in 1.2% and 7.1% of adjunctive placebo- and aripiprazole-treated patients, respectively.

Conclusion: In patients with MDD who showed an incomplete response to standard ADT, adjunctive aripiprazole is efficacious and well tolerated.

REFERENCES:

1. Patkar et.al: An open-label, rater-blinded, augmentation study of aripiprazole in treatment-resistant depression. Prim Care Companion J Clin Psychiatry 2006;8(2):82–7.
2. Simon and Nemeroff: Aripiprazole augmentation of antidepressants for the treatment of partially responding and nonresponding patients with major depressive disorder. J Clin Psychiatry 2005;66(10): 12–20.

Poster 122 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

THE PATHOPHYSIOLOGY AND DIAGNOSIS OF NONALCOHOLIC STEATOHEPATITIS: POTENTIAL TREATMENTS IN BUPROPION, MOLINDONE, TOPIRAMATE, AND ZONISAMIDE

Ajay Bhatia, M.D., B.A., *Resident, Department of Psychiatry, Ohio State University, 100 North Street, #217, Columbus, OH 43202*; Richard E. Kast, M.D.

SUMMARY:

Forty percent of the U.S. will be obese by 2008. Many psychiatric medications, but preeminently olanzapine and mirtazapine, contribute to appetite weight gain. Nonalcoholic steatohepatitis (NASH) is now the commonest

cause of chronic liver disease. It results from two distinct "hits": First, chronic overnutrition causes intracellular hepatic lipid accumulation [steatosis]. Second, oxidant stress and mitochondrial injury increase inflammatory cytokines like tumor necrosis factor-alpha, TNF. NASH should be considered in obese individuals with elevated liver function tests. Other causes of hepatitis must be ruled out (Etoh, viral). MRI, or CT are suggestive of NASH, but hepatology confirms diagnosis by liver biopsy. Current treatments for NASH include: 1.) Increased exercise; 2.) Caloric restriction resulting in weight loss [difficult]; 3.) Bariatric surgery: and 4.) Insulin sensitizing drugs (e.g., pioglitazone). Often psychiatric drugs contributing to weight gain cannot safely be withdrawn or substituted. Some psychotropic medications may augment lifestyle modifications in reducing weight and consequent NASH: molindone, topiramate, and zonisamide have been shown to reduce weight. We speculate bupropion, by downregulating TNF-alpha, may lower NASH related inflammation. Psychiatrists can help treatment of NASH by focusing on prevention, encouraging appropriate diet and exercise, and when appropriate, using drugs with lower weight gain and inflammation potential.

REFERENCES:

1. Feldstein AE, Werneburg NW, Canbay A, et.al. Free fatty acids promote lipotoxicity by stimulating TNF-alpha expression via a lysosomal pathway. Hepatology 2004; 40: 185–194.
2. Brustolim D, Ribeiro-dos-Santos R, Kast RE, et.al. A new chapter opens in anti-inflammatory treatments: the anti-depressant bupropion lowers tumor necrosis factor-alpha and interferon-gamma in mice. Int Immunopharmacol 2006; 6: 903–907.

Poster 123 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

LONG-TERM, OPEN-LABEL STUDY OF GUANFACINE EXTENDED RELEASE IN CHILDREN AND ADOLESCENTS WITH ADHD

Supported by Shire Development, Inc.

Joseph Biederman, M.D., *Clinical and Research Program in Pediatric Psychopharmacology, Massachusetts General Hospital, Harvard Medical School, 185 Alewife Brook Parkway, Suite 2000, Cambridge, MA 02114*; Raun Melmed, M.D.; Anil S. Patel, M.D.; Keith McBurnett, Ph.D.; Jessica Donahue, M.P.H.; Andrew Lyne, M.S.C.

SUMMARY:

Objective: Small, uncontrolled studies have shown that immediate-release guanfacine (a selective a2A-adrenoceptor agonist) improves symptoms of attention-deficit/hyperactivity disorder (ADHD). This study evaluated the long-term (up to 2 years) safety and efficacy of guanfacine extended release (GXR; SPD503), 2–4 mg/d, compared with placebo in subjects aged 6 to 17 years with ADHD.

Methods: Two hundred forty subjects aged 6 to 17 years with ADHD previously enrolled in a phase III randomized, double-blind trial were eligible for this extension study. GXR was increased from 2 to 4 mg once a day (in 1-mg/wk increments) to achieve optimal clinical response.

Results: The most common treatment-emergent adverse events (AEs) were somnolence (30.4%), headache (26.3%), fatigue (14.2%), and sedation (13.3%). Somnolence, sedation, and fatigue typically occurred early in the study; most resolved as treatment continued, and were mostly mild to moderate. Small reductions in mean blood pressure and mean pulse rate were evident at monthly visits; however, cardiovascular-related AEs were uncommon. ADHD Rating Scale-IV total and subscale scores improved significantly for all dose groups ($P<.001$ for all comparisons, intent-to-treat population).

Conclusions: AEs with GXR were mostly mild to moderate. Efficacy was maintained over this period for those patients who remained in the study.

REFERENCES:

1. Arnsten AF, Cai JX, Goldman-Rakic PS: The alpha-2 adrenergic agonist guanfacine improves memory in aged monkeys without sedative or hypotensive side effects: evidence for alpha-2 receptor subtypes. J Neurosci 1988; 8:4287–4298.
2. Hunt RD, Arnsten AF, Asbell MD: An open trial of guanfacine in the treatment of attention-deficit hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 1995; 34:50–54.

Poster 124 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

DOUBLE-BLIND COMPARISON OF ESCITALOPRAM AND DULOXETINE IN THE ACUTE TREATMENT OF MAJOR DEPRESSIVE DISORDER: EFFICACY, TOLERABILITY, AND TOTAL DIRECT COSTS

Supported by Forest Laboratories, Inc.

Anjana Bose, Ph.D., *Research Department, Forest Laboratories, Inc., Harborside Financial Center, Plaza V, Suite 1900, Jersey City, NJ 07311*; Chetan Gandhi, Ph.D.; Arif Khan, M.D.; M. Haim Erder, Ph.D.; George S. Alexopoulos, M.D.

SUMMARY:

Objective: Evaluate the efficacy, tolerability, and total direct costs of escitalopram versus duloxetine in the treatment of major depressive disorder.

Methods: A total of 270 outpatients were randomized to 8 weeks of double-blind treatment with escitalopram 10–20 mg/day (dose fixed at 10 mg/day for the first 4 weeks with optional up-titration to 20 mg/day thereafter) or duloxetine 60 mg/day.

Results: Significantly more patients discontinued treatment in the duloxetine group than in the escitalopram group 31% vs. 13%, respectively (P=0.001). At Week 8, escitalopram treatment resulted in significantly greater improvement compared with duloxetine on the prospectively-defined primary efficacy endpoint of change from baseline in MADRS (LOCF) (P=0.040). Remission (MADRS=10) rates were 44% for escitalopram and 38% for duloxetine. Significantly fewer escitalopram-treated patients discontinued due to adverse events compared with duloxetine (2% vs. 13%, respectively; P=0.001). According to the cost minimization model, switching patients from duloxetine to escitalopram decreased managed care total cost of treatment per patient by about 46%.

Conclusions: These findings suggest that escitalopram is better tolerated and at least as effective as duloxetine in the treatment of MDD. Switching MDD patients treated with duloxetine to escitalopram offers costs savings to managed care.

REFERENCES:

1. Sullivan PW. A comparison of the direct costs and cost effectiveness of serotonin reuptake inhibitors and associated adverse drug reactions. CNS Drugs 2004:18:911–932.
2. Hirschfeld RM. Newer antidepressants: review of efficacy and safety of escitalopram and duloxetine. J Clin Psychiatry 2004;65 Suppl 4:46–52.

Poster 125 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

COMPARISON OF ESCITALOPRAM AND DULOXETINE IN THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

Supported by Forest Laboratories, Inc.

Anjana Bose, Ph.D., *Research Department, Forest Laboratories, Inc., Harborside Financial Center, Plaza V, Suite 1900, Jersey City, NJ 07311*; Carl Gommoll, M.D.; Dayong Li, Ph.D.; Chetan Gandhi, Ph.D.

SUMMARY:

Objective: This post-hoc analyses will investigate the effect of treatment on single Montgomery-Asberg Depression Rating Scale (MADRS) items.

Methods: Outpatients with MDD were randomized to 8 weeks of double-blind treatment with escitalopram 10–20 mg/day or duloxetine 60 mg/day. The primary efficacy endpoint was change from baseline in MADRS total score using the last observation carried forward (LOCF) approach. Post-hoc analyses were conducted on change from baseline in MADRS single items; no corrections were made for multiple comparisons.

Results: Post-hoc analysis on MADRS single items found that escitalopram treatment resulted in statistically significantly greater improvement than duloxetine on six of ten MADRS items (LOCF) including apparent sadness (LSMD –0.41, P=0.012), reported sadness (LSMD –0.37, P=0.036), inner tension (LSMD –0.31, P=0.041), reduced sleep (LSMD –0.45, P=0.018), lassitude (LSMD –0.45, P=0.0092), and suicidal thoughts (LSMD –0.25, P=0.0). Escitalopram and duloxetine resulted in comparable improvement on the remaining four MADRS items. When analyzed using the OC approach, the differences between the treatment groups did not achieve statistical significance.

Conclusions: These results indicate that the statistically significant improvement with escitalopram treatment compared with duloxetine on the primary efficacy measure of MADRS total score was based on a balanced effect across a majority of MADRS items.

REFERENCES:

1. Hirschfeld RM. Newer antidepressants: review of efficacy and safety of escitalopram and duloxetine. J Clin Psychiatry 2004;65 Suppl 4:46–52.
2. Wade A, Gembert K, Florea I. A comparative study of the efficacy of acute and continuation treatment with escitalopram versus duloxetine in patients with major depressive disorder. Curr Med Res Opin 2007;23(7):05–14.

Poster 126 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

COGNITIVE PERFORMANCE IN NORMAL-PRESSURE HYDROCEPHALUS: A PRELIMINARY STUDY

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Paula Ana Braga, M.Psy.; Adriana Fregonese, M.Psy.

SUMMARY:

Objective: Normal-Pressure Hydrocephalus (NPH) is a frequently reversible dementia. The aim of this study is evaluate cognitive functions associated with this pathology to determine the benefits of possible ventricular derivation, analyzing their impairments.

Methods: A group of 13 patients (8 male and 5 female) have been evaluated before surgery, by a neuropsychologist who used a cognitive tracing protocol of six neuropsychological tests, to assess functions like attention, memory, language, visuospatial and executive functions. In this group, 5 patients were evaluated another time after the surgery. This study was realized from November 2004 to March 2006, at Discipline of Neurology and Neurosurgery of the Irmandade da Santa Casa de Misericórdia de São Paulo.

Results: In the pre-operatory period, 10 (77%) patients revealed attention deficit and memory impairment. Language dysfunction were observed in 4 (30,7%), visualspatial impairments in 3 (23%) patients, and in the executive functions 3 (23%) revealed impairments. In these patients, 4 (30,7%) had results similar in dementia's patients in latest stages. The patients, who are evaluated after surgery, increased their results in tests that assess attention and short-term memory. In long-term memory, the results change very little. In the other functions weren't changes.

Conclusions: In this study, the principal cognitive impairments in Normal-Pressure Hydrocephalus's patients were in attention and memory functions, in agreement with literature. And these functions were that increase with derivation procedure. Based on this data, the importance of neuropsychological evaluation on NPH's patients is noticed like a exam that to help the clinician to determine the better procedure to their patient.

REFERENCES:

1. Nitrini, R. – Conceitos anatômicos Básicos em Neuropsicologia. In: Nitrini, R.; Caramelli, P. & Mansur, L. L. (Orgs.), Neuropsicologia: Das Bases Anatômicas à Reabilitação. HCFMUSP. São Paulo, 1996.
2. Wilson, B. – Resultados da Reabilitação Neuropsicológica do Centro Olivier Zangwill. Comunicação pessoal da autora. Hospital Israelita Albert Einstein. São Paulo, 2000.

Poster 127 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

QUALITY OF LIFE, DEPRESSIVE SYMPTOMS, AND PHYSICAL CAPACITY OF PATIENTS AWAITING LIVER TRANSPLANTATION AND OF PATIENTS WHO HAVE ALREADY UNDERGONE LIVER TRANSPLANTATION.

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Rosana Rodrigues, M.Psy.; Luis Nogueira-Martins, Psy.D.; Lucia Horta Ana, Ph.D.; Adriana Fregonese, M.Psy.

SUMMARY:

Objective: To evaluate and compare QOL (quality of life), prevalence of depressive symptoms and degree of physical dependence of transplanted patients with chronic hepatic disease and those awaiting liver transplant.

Methods: The sample showed thirty patients, 15 transplanted and 15 awaiting transplant. The following instruments were used: Short-form Health Survey (SF-36), Beck Depression Inventory (BDI), Karnofsky Performance Status (KPS) and the Child Turcotte Pugh (CTP) and Model for End-Stage Liver Disease (MELD) to classify the gravity of the disease. We used the SPSS for Windows, Version 6.0 database for the statistical analysis. The Mann-Whitney test and Pearson's correlation coefficient were used for statistical analysis. The significance level adopted was of $p=0.05$ for all the statistical tests in this study. The results of transplanted patients' QOL were better in the physical component domains: Functional Capacity ($p=0.031$) and General Health Perceptions ($p=0.015$) and worse in the SF-36 mental component domains: Emotional Aspects ($p=0.019$) and Social Aspects ($p=0.010$). The KPS results demonstrated a tendency of the transplanted patients to present a lower degree of physical dependency than patients in the waiting list, though statistical significance was not established ($p=0.8$). The BDI results revealed a tendency of the transplanted patients to present higher depression scores than waiting list patients though statistical significance was not established ($p=0.786$). The CTP presented a direct significant correlation with the SF-36 Pain domain and with the KPS. Regarding the MELD, a direct correlation was found only with the BDI.

Conclusions: Transplanted patients showed an improvement in their physical capacity and quality of life regarding the physical component, even though they had higher depression scores, however, demonstrated a worsening regarding their psychosocial condition.

REFERENCES:

1. Nickel R, Wunsch A, Egle UT, et.al.: The relevance of anxiety, depression, and coping in patients after liver transplantation. Liver Tranplantation 8:63, 2002.
2. O'Carroll RE, Couston M, Cossar J, et.al.:Psychological outcome and quality of life following liver transplantation: a prospective, national, single-center study. Liver Transplantation 9:712, 2003.

Poster 128

Saturday, October 13
8:30 a.m.-10:00 a.m.

TREATMENT SATISFACTION AFTER CONVERSION FROM ORAL TO TRANSDERMAL METHYLPHENIDATE

Supported by Shire Development, Inc.

Jeanne Landgraf, M.D., *Employee, HealthActCHQ, Inc.*; Arnold L. Eugene M.D.; Micheal McKay, M.D.

SUMMARY:

Objectives: Evaluate the efficacy, safety, and treatment satisfaction of methylphenidate transdermal system (MTS) in children with attention-deficit/hyperactivity disorder (ADHD) previously treated with oral extended release methylphenidate (XR-MPH).

Methods: In a 4-week, open-label study, children (6–12 years) currently on a stable oral XR-MPH dose, were abruptly converted to MTS based on their previous oral XR-MPH dose. Subjects received the converted MTS dose for 1-week, then underwent a 2-week dose-adjustment period and remained on their optimized MTS dose for 1-week. Efficacy measures included the ADHD-RS-IV rating scale. The ADHD Impact Module Children (AIM-C© 1998–2006 HealthActCHQ, Inc.) assessed parent-rated quality of life (QoL); the Medication Satisfaction Survey (MSS) included physician- and parent-rated satisfaction with MTS use.

Results: Compared with baseline, ADHD-RS-IV mean total scores (P<.0001) and AIM-C mean scores improved at endpoint; AIM-C scores improved regardless of previous oral XR-MPH treatment. Most physicians and parents reported satisfaction with MTS. Adverse events were generally mild to moderate in severity. Four serious adverse events were reported in 2 subjects.

Conclusions: Comparing endpoint with baseline, MTS was effective in reducing ADHD symptoms, reducing the impact of ADHD on the lives of children and their families, and in improving treatment satisfaction, as measured by the AIM-C and MSS.

REFERENCES:

1. McGough JJ, Wigal SB, et.al. A randomized, double-blind, placebo-controlled, laboratory classroom assessment of methylphenidate transdermal system in children with ADHD. Journal of Attention Disorders. 2006;9:3:476–485.
2. Landgraf JM, Rich M, Rappaport L. Measuring quality of life in children with attention-deficit/hyperactivity disorder and their families: development and evaluation of a new tool. Arch Pediatr Adolesc Med. 2002;156(4):384–91.

Poster 129

Saturday, October 13
8:30 a.m.-10:00 a.m.

COSTS OF GUIDELINE-RECOMMENDED DOSING OF SECOND-GENERATION ANTIPSYCHOTICS FOR SCHIZOPHRENIA

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Chi-Chang Chen, Ph.D., *Manager, Outcomes Research, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Plainsboro, NJ 08536*; Edward Kim, M.D.; Hongjun Kan, Ph.D.; Yanni Yu, Ph.D.; Richard Whitehead, B.S.

SUMMARY:

Objective: To compare the drug-acquisition costs of second-generation antipsychotics (SGAs) at guideline-recommended doses with real-world practice doses in a population with private health insurance coverage.

Method: This was a retrospective cohort study using PharMetrics data (2003–2005) to determine: the real-world frequency distribution of SGA monotherapy doses in patients with schizophrenia, and the frequency distribution within the recommended dosing ranges specified in the 2003 Expert Consensus Guideline for the Treatment of Psychotic Disorders. Acquisition costs were estimated using the 2007 wholesale list price for each drug.

Results: The mean per-patient-per month (PPPM) costs for the real world (median dose) and recommended dose range were: aripiprazole US$ 456 (15 mg/day) and US$ 463 (15–20 mg/day); quetiapine US$ 378 (300 mg/day) and US$ 481 (400–750 mg/day); risperidone US$ 364 (3 mg/day) and US$ 394 (3.5–5.5 mg/day); olanzapine US$ 594 (11.5 mg/day) and US$ 626 (12.5–22.5 mg/day); ziprasidone US$ 338 (130 mg/day) and US$ 401 (120–180 mg/day).

Conclusions: The real-world dosing of SGAs is lower than that recommended by treatment guidelines. Dosing within the guideline-recommended range is associated with increased drug-acquisition costs. The cost difference between actual and recommended dosing is lowest with aripiprazole (US$ 7 PPPM) and highest with quetiapine (US$ 103 PPPM).

REFERENCES:

1. Expert Consensus Panel for Optimizing Pharmacologic Treatment of Psychotic Disorders. The expert consensus guideline series. Optimizing pharmacologic treatment of psychotic disorders. J Clin Psychiatry 2003; 64 (Suppl 12):2–97.
2. Gianfrancesco F, Wang RH, Pesa J. Relationship between initial quetiapine dose and effectiveness as reflected in subsequent mental health service use

among patients with schizophrenia or bipolar disorder. Value in Health 2005; 8:471–478.

Poster 130 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

REAL-WORLD DOSING PATTERNS OF SECOND-GENERATION ANTIPSYCHOTICS AND ADHERENCE

Supported by Bristol-Myers Squibb Company

Chi-Chang Chen, Ph.D., *Manager, Outcomes Research, Bristol-Myers Squibb Company, 777 Scudders Mill Road, Plainsboro, NJ 08536*; Myoung Kim, Ph.D.; Edward Kim, M.D.; Quynh-Van Tran, Pharm.D.

SUMMARY:

Purpose: This study described real-world dosing patterns of second generation antipsychotics (SGAs), and examined the relationship between dosing and treatment adherence.

Method: Patients with an SGA claim (aripiprazole, lanzapine, quetiapine, risperidone, or ziprasidone) between July 1, 2003 and June 30, 2004, with one year continuous enrollment after index prescription, were extracted from a large claims database (PharMetrics). For patients with at least three, 30-day prescriptions, distributions of average daily dose of last prescriptions for each SGA during the one-year follow-up period were stratified by the following: psychiatric diagnosis (schizophrenia, bipolar disorder, both schizophrenia and bipolar disorder, and all others); treatment regimen (monotherapy, combination with other atypical, combination with typical, and combination with other atypical and typical); and adherence (measured by persistent days). Relationship between dosing and persistence was examined by survival analysis.

Results: A total of 56,414 patients were included. Among schizophrenia patients (n=2,779), median daily doses of last prescription were generally within the label recommended dosing range (quetiapine, 327 mg/day; olanzapine, 15 mg/day; risperidone, 3 mg/day; aripiprazole, 20 mg/day; and ziprasidone, 0 mg/day). Compared to schizophrenia, doses in bipolar disorder patients (N= 19,060) were found to be generally below or on the lower end of label-recommended dosing range (quetiapine, 110 mg/day; olanzapine, 7.5 mg/day; risperidone, 1.25 mg/day; aripiprazole, 15 mg/day; and ziprasidone, 80 mg/day). Kaplan-Meier survival curves showed that for all second-generation antipsychotics (SGAs), patients in the higher dosing groups had consistently lower risk of treatment discontinuation during the follow-up period. After adjusting for age, sex, psychiatric diagnosis, treatment regimen, and concomitant mood stabilizers, for every 1 mg/day increase in SGA dosing, risk of treatment discontinuation was reduced by 0.1 to 8%.

Conclusion: This analysis demonstrates the considerable dosing variation of all SGAs in clinical practice. The degree of variation varied by antipsychotic, psychiatric diagnosis, and treatment regimen. Cox proportional hazards models indicated that, for each SGA, higher dosing level is generally associated with better persistence.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, et.al. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med. 2006;353 (12):1209–1223.
2. Citrome L, Volavka J. Optimal dosing of atypical antipsychotics in adults: a review of the current evidence. Harv Rev Psychiatry. 2002;10(5):280–291.

Poster 131 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

PREDICTORS OF SUCCESSFUL ARIPIPRAZOLE INITIATION IN PATIENTS WITH SCHIZOPHRENIA

Supported by Bristol-Myers Squibb Company

Tanya J. Fabian, Ph.D., Pharm.D., *Director of Pharmacy Research, Room E-831, Western Psychiatric Insititute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; Kim Coley, Pharm.D.; Edward Kim, M.D.; Diane Ammerman, Pharm.D.; Myoung Kim, Ph.D.; Richard Whitehead, B.S.; Rohan Ganguli, M.D.

SUMMARY:

Objective: To determine patient and treatment factors associated with successful initiation of aripiprazole in inpatients with schizophrenia and schizoaffective disorder.

Methods: This was a retrospective cohort study using a medical record data repository at Western Psychiatric Institute and Clinic. Adults admitted between 1/1/03 and 6/30/06 for schizophrenia/schizoaffective disorder who were newly treated with aripiprazole were included. Treatment success was defined as continuing aripiprazole from initiation through discharge. Univariate logistic regression was performed with treatment success as the dependent variable and demographics, prior treatment, aripiprazole dosing, and concomitant psychotropic medications as independent variables. A multivariate logistic regression was performed using variables from the univariate analyses that were significant at $p<0.1$.

Results: Of 479 patients, 308 (64.3%) met criteria for treatment success. Multivariate logistic regression identified predictors of success including: upward dose titration within 3 days of admission (OR=1.97, p=0.003);

concomitant antidepressant treatment (OR=1.84, p=0.006); priorpsychiatric hospitalization (OR 1.57, p=0.036); higher maximum aripiprazole dose (OR 1.04, p=0.001). Use of concomitant antipsychotics (OR=0.35, p<0.001) or anticholinergic agents (OR=0.51, p=0.003) were associated with treatment failure.

Conclusions: Initiation of acute treatment with aripiprazole was successful in 64% of inpatients with schizophrenia/schizoaffective disorder. Patient and treatment factors associated with treatment success and failure were identified.

REFERENCES:

1. Bettinger TL, Shuler G, Jones DR, Wilson JP. Schizophrenia: multi-attribute utility theory approach to selection of atypical antipsychotics. Ann Pharmacother 2007;41(2):201–7.
2. McCue RE, Waheed R, Urcuyo L, et.al. Comparative effectiveness of second-generation antipsychotics and haloperidol in acute schizophrenia. Br J Psych 2006;189:433–40.

Poster 132 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

ARIPIPRAZOLE IN PATIENTS WITH MAJOR DEPRESSIVE DISORDERS: IMPACT ON FUNCTIONAL DISABILITY

Supported by Bristol-Myers Squibb Company and Otsuka Pharmaceuticals, Inc.

Patricia K. Corey-Lisle, Ph.D., R.N., *Associate Director, Department of Pharmaceutical Research, Bristol Myers Squibb Company, 5 Research Parkway, Wallingford, CT 06492*; Robert M. Berman, M.D.; Rene Swanink, M.S.; Robert D. McQuade, Ph.D.; Gilbert L'Italien, Ph.D.

SUMMARY:

Objective: Functional disability is common in psychiatric disorders (1). We assessed the functional impact of adjunctive aripiprazole in patients with major depressive disorder who showed an incomplete response to =1 historical and one prospective standard antidepressant therapy (ADT) using the Sheehan Disability Scale (SDS) (2) in a multicenter, randomized, double-blind, 6-week, placebo-controlled trial.

Methods: The key secondary endpoint was the change in SDS mean score from baseline. Treatment comparisons of SDS mean score and sub-scale scores (social, family, work) were carried out using ANCOVA.

Results: In the last observation carried forward (LOCF) analyses, the mean change in SDS score in patients receiving aripiprazole was −1.11 versus −0.65 for placebo (p=0.055). In the OC analysis, mean change in total scores was −1.17 for aripiprazole vs −0.64 for placebo (p=0.037). Item scores for family life and social disability favored aripiprazole (p=0.030 and 0.017, respectively; LOCF). Work disability item differences were non-significant between groups.

Conclusion: The SDS provides an important perspective on patient-reported functional impairment. Treatment with adjunctive aripiprazole plus ADT in patients who showed an incomplete response to standard ADT is associated with patient-perceived benefits relating primarily to family life and social functioning.

REFERENCES:

1. Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS. The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). JAMA 2003;289:3095–3105.
2. Leon AC, Shear MK, Portera L, Klerman GL. Assessing impairment inpatients with panic disorder: The Sheehan Disability Scale. Social Psychiatric Epidemiology 1992;27:78–82.

Poster 133 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

LAMOTRIGINE IMPROVED ADAS-COG SCORES IN SUBJECTS WITH DEMENTIA AND CONCURRENT PSYCHOSIS

Supported by GlaxoSmithKline

Ovidio A. De Leon, M.D., *Professor of Psychiatry, University of Illinois at Chicago, 912 S. Wood Street, Chicago, IL 60612*; Henry Riordan, Ph.D.; Christine Moore, Ph.D.; Paul Greene, Ph.D.

SUMMARY:

Objective: Lamotrigine has been shown to improve scores in a controlled study of patients with Alzheimer's disease (AD) and may have antipsychotic effects as demonstrated in studies of other psychiatric disorders. We evaluated the efficacy of lamotrigine (maximum dose 400mg/day) versus placebo as adjunctive therapy in treating psychosis in subjects with dementia for 10 weeks.

Methods: Medically stable subjects at least 50 years old with current psychosis associated with AD, vascular dementia, or mixed dementia were eligible for participation. A Mini-Mental State Examination (MMSE) score of 14 to 26 and a score of 3 or higher on any hallucination and delusion items of the Neuropsychiatric Inventory-Nursing Home edition (NPI/NH) were required. Subjects with a history of any psychiatric disorder with psychotic symptoms were excluded. Stable concomitant psychotropic therapy was permitted.

Results: Twenty-one subjects were randomly assigned to treatment (12 lamotrigine, nine placebo). More than half (62%) of subjects was female; overall mean age was 76.7 (SD=10.6) years. Baseline MMSE scores were comparable between treatment groups (19.2[4.4] and 18.3[4.3] for lamotrigine and placebo, respectively). Six patients discontinued treatment early (5 lamotrigine, 1 placebo), two taking lamotrigine due to adverse events. No adverse events lead to discontinuation in the placebo group. No significant treatment differences were noted in the change from baseline to endpoint on measures of psychosis. However, there was a significant improvement in the total Alzheimer's Disease Assessment Scale (ADAS-Cog) score at week 10 (mean change [SE]- −3.64 [1.9] and 5.01 [2.1] for lamotrigine and placebo respectively, using a last observation carried forward approach; p=0.007).

Conclusion: Adjunctive lamotrigine was not effective in treating psychosis in elderly demented subjects as measured by traditional psychiatric scales. However, short- term adjunctive treatment with lamotrigine appeared to improve the overall cognitive performance of subjects with dementia who have psychotic symptoms.

REFERENCES:

1. De Leon, OA. Treatment of psychotic symptoms with lamotrigine in Alzheimer's Disease. J Clin Psychopharmacol. 2004. Apr; 24 (2): 232–3.
2. Tekin S, Aykut-Bingol C, Tandirag T et.al. Antiglutamatergic therapy in Alzheimer's disease-effects of lamotrigine. J Neural Transm. 1998;105:295–303.

Poster 134 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

PALIPERIDONE EXTENDED-RELEASE IN PATIENTS WITH SCHIZOPHRENIA AND PROMINENT AFFECTIVE SYMPTOMS

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Bryan Dirks, M.D., M.S., *Associate Director, Research Physician, Janssen Pharmaceutica, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Cynthia A. Bossie, Ph.D.; Ibrahim Turkoz, Ph.D.; Ramy Mahmoud, M.D.; Andreas Schreiner, Ph.D.; Carla M. Canuso, M.D.

SUMMARY:

Objective: To evaluate the safety and efficacy of paliperidone extended-release (ER) in patients with schizophrenia who presented with prominent affective symptoms.

Methods: This post-hoc analysis used pooled data from three, 6-week, randomized, double-blind, placebo-controlled studies. Prominent affective symptoms were defined as PANSS depression item score of >=5 and/ or grandiosity score of >=4, plus a score of >=4 on at least one of the following: excitement, hostility, uncooperativeness, or poor impulse control. Subjects received fixed doses of paliperidone ER 3–12 mg/day or placebo. Assessments included PANSS, CGI-S, PSP, and adverse events (AE).

Results: 193 patients with prominent affective symptoms were identified (paliperidone ER 3–12 mg/day, n= 140; placebo, n=53). Paliperidone ER vs. placebo showed significant improvements in PANSS total (−20.5[23.8] vs −6.3[27.2]; P<0.001) and all factor scores (P<0.01). Significant improvements were also seen in PSP (7.2[15.8] vs 0.4[14.6]; P=0.004), and CGI-S (−0.9[1.2] vs −0.3[1.2]; P<0.001). The most common AEs with paliperidone ER vs. placebo were headache (.4% vs 13.2%), insomnia (7.9% vs 9.4%), akathisia (7.1% vs 1.9%), and sedation (7.1% vs 3.8%).

Conclusions: Paliperidone ER was associated with significantly greater improvements in symptomatology and functioning vs. placebo in patients with schizophrenia having prominent affective symptoms.

REFERENCES:

1. Emsley RA, Oosthuizen PP, Joubert AF, e.al: Depressive and anxiety symptoms in patients with schizophrenia and schizophreniform disorder. J Clin Psychiatry 1999; 60:747–751.
2. Kane J, Canas F, Kramer M, et.al: Treatment of schizophrenia with paliperidone extended-release tablets: a 6-week placebo-controlled trial. Schizophr Res 2007; 90:147–1.

Poster 135 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

COMPARISON OF TOTAL DIRECT MEDICAL COSTS TO MANAGED CARE OF ESCITALOPRAM VERSUS DULOXETINE IN MAJOR DEPRESSIVE DISORDER

Supported by Forest Research Institute

M. Haim Erder, Ph.D., *Executive Director, Health Economics, Forest Research Institute, Harborside Financial Center, Plaza V, Jersey City, NJ 07311*; Cheng Wang, M.D.

SUMMARY:

Objective: To compare, from a managed care perspective, the total direct medical costs of escitalopram and duloxetine in major depressive disorder (MDD).

Methods: Patients received double-blind escitalpram (10–20 mg/day, N=137) or duloxetine (60 mg/day, N= 133) in an 8-week trial. A cost-minimization model was

developed that assumed no differences in study clinical outcomes. Office visits to treat AEs and manage switching were modeled. AE treatment costs were taken from the literature and expert advice. Office visit costs were derived from secondary databases. Escitalopram and duloxetine costs, $2.81/day (20 mg) and $3.84/day (60 mg), respectively, were assumed at average wholesale price (AWP), discounted 20% for managed care.

Results: There were significantly more dropouts due to AEs with duloxetine than escitalopram (12.8% and 2.2%, respectively; P<0.01). According to the cost-minimization model, treating with escitalopram decreased total cost of treatment per patient by about 46%, from $210 to $112. One-way sensitivity analyses that assumed either no withdrawals or no AEs in the duloxetine-treatment arm showed that escitalopram treatment resulted in cost savings of 42% or 40%, respectively.

Conclusion: Switching MDD patients from duloxetine to escitalopram offers cost savings estimated at $9,800 per 100 patients switched, which could be used to treat 87 additional patients with escitalopram.

REFERENCES:

1. Sullivan PW. A comparison of the direct costs and cost effectiveness of serotonin reuptake inhibitors and associated adverse drug reactions. CNS Drugs 2004:18:911–932.
2. Hirschfeld RM. Newer antidepressants: review of efficacy and safety of escitalopram and duloxetine. J Clin Psychiatry 2004;65 Suppl 4:46–52.

Poster 136 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

POTENTIAL DRUG-DRUG INTERACTIONS WITH RISPERIDONE AND THE RISK OF DISCONTINUATION: A RETROSPECTIVE ANALYSIS OF PATIENTS IN QUEBEC, CANADA

Supported by Janssen-Ortho, Inc.

Jennifer R. Glass, Ph.D., *Manager, Health Economics and Reimbursement, Janssen-Ortho, Inc., 19 Green Belt Drive, Toronto, ON, Canada M3C 1L9*; Jack K. Ishak, Ph.D.; Ye Tan, Ph.D.; Doanh Luong, M.S.C.; Jaime J. Caro, M.D.

SUMMARY:

Introduction: Risperidone is a commonly used antipsychotic that is metabolized primarily by CYP2D6 and CYP3A4 enzymes. There is a risk of drug-drug interactions with medications that inhibit or induce these enzymes, which may affect clinical outcomes in schizophrenia.

Objective: To quantify association between exposure to inhibitors and inducers of CYP3A4 and CYP2D6 and the risk of discontinuation of risperidone in patients with schizophrenia.

Methods: A nested case-control study was conducted using claims data from patients diagnosed with schizophrenia and at least 2 successive claims for risperidone. Cases were patients that discontinued risperidone. Ten time-matched controls were randomly chosen for each case. Exposure was defined as use of an inhibitor or inducer in the one, three and six months prior to the case time. The association between exposure and discontinuation was measured using conditional logistic regression.

Results: The base cohort included 22,762 patients, of which 11,606 became cases. No association was observed with use of inducers. Exposure to inhibitors was associated with a 10% (95%CI: 06%–14%) increase in the risk of discontinuation over a three-month window, and 11% (07%–15%) over six months.

Conclusion: Co-medication with an inhibitor of CYP2D6 or 3A4 may be associated with a greater risk of discontinuation of risperidone.

REFERENCES:

1. Sandson, N. Drug-drug interactions: The silent epidemic. Psych. Serv. 2005 56(1): 22–24.
2. de Leon, J., Susce, M., Pan, R-M, et.al. The CYP 2D6 Poor Metabolizer phenotype may be associated with risperidone adverse drug reactions and discontinuation. J Clin Psych 2005. 66:15–27.

Poster 137 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

ILOPERIDONE PHARMACOKINETICS IN SUBJECTS WITH RENAL OR HEPATIC IMPAIRMENT

Supported by Novartis Pharmaceuticals Corporation and Vanda Pharmaceuticals, Inc.

Jennifer Hamilton, M.S., *Clinical Research Scientist, Vanda Pharmaceuticals, 9605 Medical Center Drive, Suite 300, Rockville, MD 20850*; Curt Wolfgang, Ph.D.; Greg Sedek, M.D.

SUMMARY:

Introduction: Single-dose pharmacokinetics (PK) of iloperidone (a mixed D2/5-HT2 antagonist antipsychotic),1,2 and metabolites P88 (active) and P95 (inactive with respect to CNS activity) were assessed in adults with renal or hepatic impairment.

Methods: Study 1: Ten adults with chronic severe renal impairment and 13 healthy controls received single iloperidone 3-mg oral doses. Study 2: Eight adults with

mild-to-moderate hepatic impairment and 8 healthy controls received single iloperidone 2-mg doses. Blood and urine samples were collected at protocol-specified intervals to determine iloperidone, P88, and P95 PK.

Results: S1: In renally impaired subjects, iloperidone clearance was reduced, mean maximum plasma concentration (Cmax) was unaltered, and half-life (t1/2) was significantly prolonged. P88 PK was not significantly altered. Appearance and elimination of P95 were slower, and plasma concentrations were higher. S2: In hepatically impaired subjects, Iloperidone PK was essentially unaltered. P88 Cmax and AUC0-t were significantly increased. iloperidone was well tolerated by all subjects in both studies.

Conclusion: Renal dysfunction did not alter iloperidone and P88 PK to a clinically significant extent, but P95 levels significantly increased. Iloperidone exposure was unaffected by mild-to-moderate hepatic impairment, but P88 exposure was moderately increased, suggesting a potentially increased combined exposure to pharmacologically active moieties (iloperidone + P88).

REFERENCES:

1. Kalkman HO, Subramanian N, Hoyer D: Extended radioligand binding profile of iloperidone: A broad spectrum dopamine/serotonin/norepinephrine receptor antagonist for the management of psychotic disorders. Neuropsychopharmacol 2001;25:904–914.
2. Kalkman HO, Feuerbach D, Lotscher E, Schoeffter P. Functional characterization of the novel antipsychotic iloperidone at human D2, D3, 5-HT6, and 5-HT1A receptors. Life Sciences 2003;3:1151–1159.

Poster 138 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

ARIPIPRAZOLE AUGMENTATION IN TREATMENT-RESISTANT DEPRESSION

Supported by Bristol-Myers Squibb Company

David J. Hellerstein, M.D., *Associate Professor, Clinical Psychiatry, Columbia University, 180 Fort Washington Avenue, HP#256, New York, NY 10032*; Sarai Batchelder, Ph.D.; Steven E. Hyler, M.D.

SUMMARY:

Introduction: Aripiprazole may be an effective adjunctive treatment in outpatients with unipolar depression that has been refractory to treatment with SSRI or SNRI medication.

Method: 15 subjects with a current *DSM-IV* diagnosis of MDD which had not responded to SSRI or SNRI treatment were enrolled in a 12-week, open-label study of aripiprazole with a maximum dose of 30 mg/day. Patients' current episode averaged 10.4+.6 years, with a range of 3 months to 54 years. Baseline severity averaged 29.8+6.9 on HDRS-24, and 18.8+8.8 on BDI. Patients had been treated with a mean dose of 79.2+28.2 mg/d of fluoxetine equivalents for an average of 1 year prior to starting the study. 5 subjects were on SNRI medications and 10 on SSRIs.

Results: Seven of 14 (50.0%) subjects were classified as treatment responders, as defined by at least 50% reduction in the HDRS-24 and CGI-Improvement score of 1 or 2 at week 12. Four subjects (28.6%) achieved remission, based in STAR*D criteria (HDRS-17 score <7). 26.7% (4/15) of subjects discontinued participation due to side effects. Two (40%) of 5 SNRI-treated subjects responded to aripiprazole augmentation.

Conclusions: These findings support previous studies for the effectiveness of aripiprazole in augmenting SSRIs or SNRIs in treatment-resistant major depression.

REFERENCES:

1. Hellerstein DJ (2004) Aripiprazole as an adjunctive treatment in refractory major depression. Prog in Neuropsychopharmacology and Biolog Psychiatry; 28:1347–1348.
2. Nelson JC (2003) Managing treatment-resistant major depression. J Clin Psychiatry; 64(suppl);5–12.

Poster 139 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

EFFICACY OF ZIPRASIDONE IN HOSPITALIZED PATIENTS WITH SEVERE MANIA

Supported by Pfizer Inc.

Barry K. Herman, M.D., *Regional Medical and Research Specialist, Department of Neuroscience, Pfizer Inc., 235 E. 42nd Street, New York, NY 10017*; Michael H. Allen, M.D.; Antony D. Loebel, M.D.; Francine Mandel, Ph.D.

SUMMARY:

Background: Ziprasidone is effective and well tolerated in patients with bipolar mania, as demonstrated by 2 pivotal, placebo-controlled trials.1,2.

Methods: We evaluated pooled data for subjects with baseline Mania Rating Scale (MRS) scores in the highest 10% of the severity distribution at study baseline. All subjects in this post-hoc analysis had an MRS score = 36, indicating marked severity of mania. Changes in MRS scores from baseline to days 2, 4, 7, 14, and 21 were analyzed using a Cochran-Mantel-Haenszel test to determine response, defined as a decrease in MRS score of = 50% from baseline, and remission, defined as an MRS score = 10.

Results: The proportion of subjects achieving response was significantly greater for subjects receiving

ziprasidone compared with placebo from day 7 ($p = 0.03$) through to study end point ($p < 0.001$). The proportion of subjects achieving remission was significantly greater than placebo ($p = 0.01$) at study end point. Few subjects who received placebo achieved response, and none achieved remission at any timepoint during the study.

Conclusions: Ziprasidone is effective in the treatment of patients with severe manic symptoms. This conclusion is underscored by the relatively large drug-placebo differences observed in this patient subsample.

REFERENCES:

1. Keck PE Jr, Versiani M, Potkin S, et.al. Ziprasidone in the treatment of acute bipolar mania: a three-week, placebo-controlled, double-blind, randomized trial. Am J Psychiatry. 2003;0:741–748.
2. Potkin SG, Keck PE Jr, Segal S, et.al. Ziprasidone in acute bipolar mania: a 21-day randomized, double-blind, placebo-controlled replication trial. J Clin Psychopharmacol. 2005;25:301–310.

Poster 140 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

IMPACT OF PALIPERIDONE EXTENDED-RELEASE ON HOSPITAL DAYS IN SCHIZOPHRENIA PATIENTS IN THE U.S.

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Jasmanda Wu, *Employee, Ortho-McNeil Janssen Scientific Affairs, L.L.C., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Philip G. Janicak, M.D.; Lian Mao, Ph.D.; Carla M. Canuso, M.D.

SUMMARY:

Objective: To examine the impact of paliperidone extended-release tablets (paliperidone ER) on hospital days among patients enrolled in the U.S. sites of the open label extensions (OLE) of double blind (DB) studies.

Methods: Mental health-related hospitalizations during 52 weeks before entering DB and after beginning of OLE were analyzed. Average number of hospital days per person per year in pre- and post-periods was compared using bootstrap resampling methods. Total person years were calculated for the pre- and post-periods to account for different lengths of observation.

Results: Patients' (n=215) mean (±SD) age was 41.2 (11.0) years. Most patients were male (73.0%). Average paliperidone ER treatment duration (±SD) during OLE was 7.0 days(145.0) and average dose was 10.5mg(2.0). Overall, paliperidone ER patients had means of 12.5 and 2.6 hospital days per person year in the pre- and post-periods, respectively (mean change 9.8, p<0.0001). Using the Federal Per Diem Base Rate ($575.95 per day), this reduction would result in an average cost saving of $5,644 per year.

Conclusions: Paliperidone ER patients had significantly fewer hospital days in the OLE compared to the one-year period prior to DB. Paliperidone ER may play a role in reducing mental health-related hospitalizations and associated costs for these patients.

REFERENCES:

1. Kane J, Canas F, Kramer M, et.al: Treatment of schizophrenia with paliperidone extended-release tablets: A 6-week placebo-controlled trial. Schizophrenia Research 90: 147–1, 2007.
2. Davidson M, Emsley R, Kramer M, et.al: Efficacy, safety and early response of paliperidone extended-release tablets (paliperidone ER): Results of a 6-week, randomized, placebo-controlled study. Schizophrenia Research, 2007 in press.

Poster 141 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

SWITCHING TO ZIPRASIDONE IN PATIENTS WITH SCHIZOPHRENIA: AN EIGHT-WEEK, OPEN-LABEL STUDY

Supported by Pfizer Inc.

Jill Kerrick Walker, Pharm.D., *Regional Medical and Research Specialist, Pfizer Inc., 12114 S.W. 18th Avenue, Portland, OR 97219*; Alessandro Rossi, M.D.; Antonio Vita, M.D.; Antonio Sciarretta; Fabio Romeo, M.D.; Paola Tiradritti

SUMMARY:

Schizophrenic patients experiencing inefficacy or intolerability may benefit from changing antipsychotic medication. This 8-week, open-label study evaluated the efficacy and tolerability of ziprasidone (40–0 mg/d) in 312 outpatients with schizophrenia receiving another conventional or atypical antipsychotic for >2 months. A change in medication was indicated by inefficacy (72.1%) or intolerability (26.3%). Significant improvements in PANSS total score (12.8 ± 18.9; $P < 0.0001$) and Subjective Well-Being Under Neuroleptics scale total score (+9.3 ± 20.3; $P < 0.0001$) were observed at end point. Body weight (–3.1 ± 5.7 lb; $P < 0.0001$) and body mass index (–0.5 ± 0.9 kg/m2; $P < 0.0001$) decreased significantly and were associated with significant improvements in total (13.5 mg/dL), LDL (–10.5 mg/dL), and HDL cholesterol (+1.4 mg/dL) and triglycerides (12.6 mg/dL) at end point ($P < 0.05$). Blood glucose level decreased with ziprasidone treatment (–1.8 mg/dL; P = NS). Mean QTc interval increased by 4 ms. Ziprasidone was generally well tolerated; 10.9% of patients discontinued due to adverse events. Switching

from a conventional or atypical antipsychotic to ziprasidone significantly improved efficacy and tolerability, including cardiovascular risk factors. These data support ziprasidone use for outpatients with schizophrenia whose current medication is ineffective or intolerable.

REFERENCES:

1. Weiden PJ, Daniel DG, Simpson G, Romano SJ: Improvement in indices of health status in outpatients with schizophrenia switched to ziprasidone. J Clin Psychopharmacol 2003; 23:595–600.
2. Weiden PJ, Simpson GM, Potkin SG, O'Sullivan RL: Effectiveness of switching to ziprasidone for stable but symptomatic outpatients with schizophrenia. J Clin Psychiatry 2003; 64:580–588.

Poster 142 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

EARLY ONSET ON ANTIPSYCHOTIC ACTION AND TIME COURSE IN THE TREATMENT OF ACUTE BIPOLAR MANIA

Supported by Pfizer Inc.

Holly Roberts, M.D., *Medical Director, Neuroscience, Pfizer Inc., 235 E. 42nd Street, New York, NY 10017-5755*; Terence A. Ketter, M.D.; Antony D. Loebel, M.D.; Lewis E. Warrington, M.D.

SUMMARY:

Objective: To evaluate the potential for an early antipsychotic response to oral ziprasidone in subjects with acute bipolar mania.

Methods: A pooled analysis of two 3-week, randomized, double-blind, placebo-controlled studies of ziprasidone (80–0 mg/d) in hospitalized patients (N=397) with bipolar I disorder, with (N=151) or without (N=245) psychotic features [1, 2]. Efficacy assessments included the Mania Rating Scale (derived from the SADS-C) and CGI-S administered at baseline and days 2, 4, 7, 14, and 21 (or early termination). Improvement in psychosis was evaluated by the SADS-C psychosis total score (delusions, hallucinations, and suspiciousness). MMRM analysis was used to estimate the time course of the response.

Results: Significant improvement in the SADS-C psychosis total score was observed in the ziprasidone group (versus placebo) as early as day 4 ($p<0.01$) in the subgroup of patients with psychotic symptoms at baseline, as well as in ITT subjects ($p<0.01$). The magnitude of the ziprasidone effect on psychosis increased by visit ($p<0.01$) with a significant treatment-by-visit interaction ($p<0.01$).

Conclusions: Ziprasidone is associated with a rapid onset of response in the psychotic symptoms associated with acute bipolar mania. These findings support the hypothesis that onset of antipsychotic action can occur early in the treatment of psychotic mania.

REFERENCES:

1. Keck PE Jr, Versiani M, Potkin S, et.al, for the Ziprasidone in Mania Study Group. Ziprasidone in the treatment of acute bipolar mania: a three-week, placebo-controlled, double-blind, randomized trial. Am J Psychiatry. 2003;0:741–748.
2. Potkin SG, Keck PE Jr, Segal S, et.al. Ziprasidone in acute bipolar mania: a 21-day randomized, double-blind, placebo-controlled replication trial. J Clin Psychopharmacol. 2005;25:301–310.

Poster 143 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

QUETIAPINE AUGMENTATION OF SSRIS FOR TREATMENT REFRACTORY SOCIAL ANXIETY DISORDER

Supported by AstraZeneca Pharmaceuticals

Gustavo D. Kinrys, M.D., *Director, Anxiety Disorders Research Program, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139*; Fernanda Nery; Robert Dunn, M.D.; Roberto B. Sassi, M.D., M.P.H.; Debora de Sa Vasconcelos; Ethan Rothstein

SUMMARY:

Objective: Social anxiety disorder (SAD) is a common psychiatric disorder associated with considerable emotional and social costs. Approximately 45–70% of patients fail to reach responder status after acute treatment. This is the first study to examine using adjunctive quetiapine in the treatment of refractory SAD.

Methods: Retrospective, baseline comparative analysis of patients with SAD (N=26) who were partial or non-responders to SSRI therapy (over at least 8 weeks) who received adjunctive quetiapine (mean 55.7 ± 31.2 mg/day) for at least 4 weeks in a naturalistic fashion. Changes from baseline to endpoint were evaluated by paired t-tests.

Results: Patients improved significantly compared with baseline (LSAS: 48.34 ± 22.28, $P<0.0001$; CGI-S: 3.2 ± 1.2, $P<0.0001$). LSAS decreased by a mean of 37 points at 4 weeks. Most patients (/26, 61.5%) met responder criteria (CGI-I <=2), and 46.1% (12/26) met remission criteria (LSAS <=30). Adverse events were generally mild and included sedation (8 patients), tiredness (6), tremors (2), and dizziness (2). Patients reported significant improvements in ability to function and quality of life.

Conclusion: Quetiapine may be an effective and well-tolerated augmentation strategy for SAD symptoms in patients who do not experience full response or remission with first-line agents such as SSRIs.

REFERENCES:

1. Worthington JJ 3rd, Kinrys G, Wygant LE, Pollack MH. Aripiprazole as an augmentor of selective serotonin reuptake inhibitors in depression and anxiety disorder patients. Int Clin Psychopharmacol. 2005;20:9–11.
2. Barnett SD, Kramer ML, Casat CD, et.al. Efficacy of olanzapine in social anxiety disorder: a pilot study. J Psychopharmacol. 2002:365–368.

Poster 144 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

EFFECT OF LONG-ACTING RISPERIDONE ON HOSPITALIZATIONS: 12-MONTH INTERIM ANALYSIS

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Riad Dirani, Ph.D., *Employee, Janssen Scientific Affairs, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Christopher M. Kozma, Ph.D.; Susan M. Vallow, M.D.; Lian Mao, Ph.D.; Stephen Rodriquez, M.S.; Mary J. Kujawa, M.D., Ph.D.

SUMMARY:

Objective: To evaluate mental health-related hospitalizations and ER visits in the 12 months pre- and post-initiation of risperidone long-acting injectable (RLAI).

Methods: Adult schizophrenia patients requiring RLAI treatment were eligible. Patient demographics, treatment history, health care utilization, functioning, quality-of-life, antipsychotic satisfaction, and medication use were analyzed for patients who completed >= 12 months of this observational study trial. Percentages of patients hospitalized and those with mental health-related hospitalizations and ER visits in the 12 months prior to baseline (pre-period) were compared to those during the 12 months following RLAI initiation (post-period).

Results: 109 patients met inclusion criteria. Mean age was 48.8±10.4 years; 64.2% were male. In the pre-period (before RLAI initiation), 28.4% were hospitalized vs 17.4% in the post-period (after RLAI initiation)(P= 0.046). Mean hospital days per patient across all patients decreased from 8.0±23.7 to 4.0±24.5 (P=0.008), while among those hospitalized in either period (n=43), mean hospital days decreased from 20.3±34.4 to 10.1±38.5 (P=0.008). Percentage of patients incurring ER visits decreased, from 19.6% to 9.8% (P=0.050). Mean number of ER visits decreased from 0.38±1.0 to 0.±0.6 (P= 0.056).

Conclusions: Fewer patients were hospitalized and incurred ER visits in the 12 months post-RLAI initiation.

REFERENCES:

1. Kennedy L, Craig A: Global registries for measuring pharmacoeconomic and quality-of-life outcomes. Pharmacoeconomics 2004;22:551–568.
2. Franciosa JA: The potential role of community-based registries to complement the limited applicability of clinical trial results to the community setting: heart failure as an example. Am J Manag Care 2004;10:487–492.

Poster 145 **Saturday, October 13 8:30 a.m.-10:00 a.m.**

FUNCTIONAL IMPROVEMENTS IN SCHIZOPHRENIA PATIENTS WITH LONG-ACTING RISPERIDONE

Supported by Ortho-McNeil Janssen Scientific Affairs, Inc.

Riad Dirani, Ph.D., *Employee, Janssen Scientific Affairs, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Christopher M. Kozma, Ph.D.; Susan M. Vallow, M.D.; Lian Mao, Ph.D.; Wayne MacFadden, M.D.; Stephen Rodriquez, M.S.

SUMMARY:

Objective: Examine interim data from an ongoing, 2-year observational study in schizophrenia patients initiated on risperidone long-acting injectable (RLAI).

Methods: This analysis focused on adult schizophrenia patients with >=3 visits (6 months of data) following initiation on RLAI in the Schizophrenia Outcomes Utilization Relapse and Clinical Evaluation (SOURCE) study. Data were collected every 3 months for 2 years and included patient demographics, treatment history, and Clinical Global Impressions–Severity (CGI-S), Global Assessment of Functioning (GAF), Personal and Social Performance (PSP) scale, and Strauss-Carpenter Levels of Functioning (LOF) scores.

Results: Patients (n = 198) were aged 43.8±12.0 years, male (65.2%), paranoid–type schizophrenics (64.1%), with an illness duration of 19.4±12.0 years. Significant improvements (P<0.0001) in mean (+SD) scores were observed from baseline to month 6: CGI-S improved from 4.4±1.2 to 3.7±1.1; PSP improved from 50.3±.5 to 61.6±14.3; GAF improved from 49.6±14.4 to 58.6±13.4, and overall LOF improved from .6±6.4 to 19.9±6.0.

Conclusions: These interim data suggest that schizophrenia patients treated with RLAI experience improvements in their clinical and functional status.

REFERENCES:

1. Kennedy L, Craig A: Global registries for measuring pharmacoeconomic and quality-of-lifeoutcomes. Pharmacoeconomics 2004; 22:551–568.
2. Franciosa JA: The potential role of community-based registries to complement the limited applicability of clinical trial results to the community setting: heart failure as an example. Am J Manag Care 2004; 10:487–492.

POSTER SESSION 6

Posters 146–174
Saturday, October 13

3:00 p.m.-4:30 p.m.

THE NEEDS OF SPECIAL POPULATIONS

Poster 146 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

CHARACTERISTICS OF PSYCHIATRICALLY HOSPITALIZED YOUTH REQUIRING SECLUSIONS AND RESTRAINTS

Muhammad W. Azeem, M.D., *Medical Director, Riverview Hospital for Children and Youth, 915 River Road, Middletown, CT 06457-9297*; Gary Binsfeld, M.A.; Robert B. Jones, M.D.; Catie Lee, M.B.A.; Nancy Dillon, Ph.D.

SUMMARY:

Objective: To determine the characteristics of youth requiring seclusions and restraints during inpatient psychiatric hospitalization. This will help in predicting which youth are at high risk for these intrusive procedures.

Methods: Medical records were reviewed for all youth admitted between July 2004 and March 2007 to the inpatient psychiatric hospital. Demographics and clinical characteristics were collected.

Results: 458 youth (Females 276/Males 182) were admitted between 7/2004 and 3/2007. 17.2% or 79 patients (Females 44/Males 35) required seclusion and/ or restraint. There were 278 seclusions/restraints (159 seclusions/119 restraints). 25 patients (32 %) were involved in 3 or more incidents. Mean age of patients requiring seclusion/restraint was 14.4 years. Average length of stay was 70.63 days. Major diagnoses include disruptive behavior disorders (61%), mood disorders (52%). 46 % of the patients had 3 or more Axis I diagnoses.

Conclusions: 1.) This study shows high rates of disruptive behavior disorders and mood disorders in this sample; 2.) Patients involved in 3 or more incidents have longer average length of stay (85 days) as compared to patients involved in less than 3 incidents (64 days); and 3.) Prospective studies are needed involving multiple sites, relationship of seclusions/restraints with staff/patient injuries and with use of emergency medications.

REFERENCES:

1. Donovan A, Plant R, Peller A, Siegel L, Martin A: Two year trends in the use of seclusion and restraint among psychiatrically hospitalized youths. Psychiatric Services 54:987–993, 2003.
2. Delaney KR, Fogg L: Patient characteristics and setting variables related to use of restraint on four inpatient psychiatric units for youths. Psychiatric Services 56:186–192, 2005.

Poster 147 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

PREVALENCE AND RISK FACTORS FOR DEPRESSION AND ANXIETY IN CARDIAC PATIENTS IN PAKISTAN

Muhammad W. Azeem, M.D., *Medical Director, Riverview Hospital for Children and Youth, 915 River Road, Middletown, CT 06457-9297*; Imran Khawaja, M.D.; Huma Awan, M.S.C.; Afshan Ayub, M.S.C.; Javed Iqbal, M.D.

SUMMARY:

Objective: To determine the prevalence and risk factors for depression and anxiety in cardiovascular patients in an inpatient tertiary care setting in Pakistan.

Methods: All patients admitted to a cardiac unit over a period of 8 weeks, who gave consent, were evaluated with *DSM-IV* criteria, for diagnosing major depression and generalized anxiety disorder.

Results: 100 patients entered the study. Mean age for the entire sample was 52.2 years, males 60 / females 40. Sixty-eight (33 males/35 females) met the *DSM-IV* criteria for major depression and generalized anxiety disorder or both (anxiety =, Males 3/ Females13, depression = 47, Males 28 /Females19, and depression + anxiety = 5, Males 2 / Females 3). A total of 87.5 % (35/ 40) of the entire female sample met the criteria for depression and anxiety or both. The rates of anxiety and depression were extremely high among the widows, all females (8/10, 80%) and house wives (33/37, 89%).

Conclusions: 1.) This study shows high prevalence of major depression and generalized anxiety disorder in cardiac patients in Pakistan; and 2.) Being female, housewife and widow are high-risk factors for developing depression and/or anxiety in this population, requiring close monitoring.

REFERENCES:

1. Ballenger JC, Davidson JR, Lecrubier Y et.al: Consensus statement on Depression, Anxiety and Cardiovascular disease. Journal of Clinical Psychiatry 62 (supp 8): 24–27, 2001.
2. Eaker ED, Sulivan L, Kelly-Hays M et.al: Tension and anxiety and predictors of the 10-year incidence of coronary heart disease, atrial fibrillation, and total mortality: The Framingham offspring study. Psychosomic Medicine 67: 692–696, 2005.

Poster 148 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY OF GUANFACINE EXTENDED RELEASE IN CHILDREN AND ADOLESCENTS WITH ADHD

Supported by Shire Pharmaceuticals, Inc.

Joseph Biederman, M.D., *Clinical and Research Program in Pediatric Psychopharmacology, Massachusetts General Hospital, Harvard Medical School, 185 Alewife Brook Parkway, Suite 2000, Cambridge, MA 02114; Raun Melmed, M.D.*; Anil S. Patel, M.D.; Keith McBurnett, Ph.D.; Jessica Donahue, M.P.H.; Andrew Lyne, M.S.C.

SUMMARY:

Objective: Guanfacine is a selective a2A-adrenoceptor agonist; small studies have demonstrated the efficacy of immediate-release guanfacine for the treatment of attention-deficit/hyperactivity disorder (ADHD). In this study, the safety and efficacy of guanfacine extended release (GXR; SPD503) were assessed in children and adolescents with ADHD.

Methods: In a double-blind study, subjects aged 6–17 years were randomized to once-daily doses of 2–4 mg GXR or placebo. The primary endpoint was change in ADHD Rating Scale (ADHD-RS-IV) score. Other efficacy measures included Clinical Global Impressions-Improvement (CGI-I) Scale and the Parent Global Assessment (PGA). Effect size was determined by post-hoc analysis of ADHD Rating Scale (ADHD-RS-IV) by weight-adjusted actual doses.

Results: For all GXR groups, improvements in ADHD-RS-IV, CGI-I and PGA scores, and duration of effect, were significant. Weight-adjusted effect sizes were 0.44 (0.01–0.04 mg/kg), 0.58 (0.05–0.08 mg/kg), 1.19 (0.09–0.12 mg/kg), and 1.34 (0.13–0.17 mg/kg). A secondary subgroup efficacy analysis versus placebo was significant for children 6–12 years old, but not for adolescents of greater weight aged 13–17. Adverse events were mild to moderate and mostly related to somnolence, sedation, and fatigue.

Conclusions: Effect sizes increased with increasing weight-adjusted dose. Further dosing analysis is needed for adolescent subjects.

REFERENCES:

1. Arnsten AF, Steere JC, Hunt RD: The contribution of alpha 2-noradrenergic mechanisms of prefrontal cortical cognitive function. Potential significance for attention-deficit hyperactivity disorder. Arch Gen Psychiatry 1996; 53:448–455.
2. Scahill L, Chappell PB, Kim YS, Schultz RT, Katsovich L, Shepherd E, Arnsten AF, Cohen DJ, Leckman JF: A placebo-controlled study of guanfacine in the treatment of children with tic disorders and attention deficit hyperactivity disorder. Am J Psychiatry 2001; 158:1067–1074.

Poster 149 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

SURVEY EVALUATION OF THE ABUSE POTENTIAL OF PRESCRIPTION STIMULANTS AMONG PATIENTS WITH ADHD

George M. Bright, M.D., *Medical Director, Adolescent Health, 13821 Village Mill Drive, Suite B, Midlothian, VA 23114*

SUMMARY:

Introduction: Research has suggested that the abuse potential of short-acting stimulants is greater than that of long-acting stimulants. This survey was used to investigate the abuse potential of commonly used short-acting and long-acting prescription stimulant medications subjects receiving treatment for attention-deficit/hyperactivity disorder (ADHD).

Methods: This is an analysis of a survey distributed to respondents enrolled in an ADHD treatment center. In addition to general information about illicit drug use and misuse of prescribed stimulant medications, respondents were polled about the type of stimulant medication most frequently misused/abused (short-acting or long-acting) and how the stimulant was prepared and administered (crushed and inhaled; crushed and injected; soaked overnight in water and injected or consumed orally;

heated in a microwave to melt down and inject, drink, or snort).

Results: From a total of 545 surveys included in this analysis, 486 (89.2%) of respondents had a diagnosis of ADHD. Results indicated that 19.4% (n=99) of subjects surveyed abused prescription stimulants. Among these subjects, 79.8% (n=79) abused short-acting agents, 17.2% (n=17) abused long-acting agents, and 2.0% (n= 2) abused both short- and long-acting stimulants. The most frequently reported method of preparation was crushing and inhalation (n=71, 74.7%) followed by crushing and injection or melting and snorting (6.3%, n=6, each).

Conclusions: In this analysis of data from a survey on abuse potential, nearly one-fifth of the respondents abused prescription stimulant medications. Short-acting prescription stimulants were more likely than long-acting agents to be misused/abused. This suggests a relative benefit of long-acting stimulants in ensuring appropriate stimulant use and decreased stimulant misuse/diversion. However, considering that there is still a potential for abuse with long-acting stimulants, additional research is warranted to identify ADHD compounds with even less potential for misuse/abuse/diversion.

REFERENCES:

1. Foltin RW, Fischman MW: Assessment of abuse liability of stimulant drugs in humans: a methodological survey. Drug Alcohol Depend 1991;28:3–48.
2. Kollins SH, Rush CR, Pazzaglia PJ, Ali JA: Comparison of acute behavioral effects of sustained-release and immediate-release methylphenidate. Exp Clin Psychopharmacol 1998;6:367–374.

Poster 150 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

EVALUATION OF THE BODY IMAGE IN CHILDREN AND TEENAGERS WITH PROMINENT EARS: A PRELIMINARY STUDY

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Fernando Ribeiro, D.M.; Sabrina Rahal, M.Ed.

SUMMARY:

Objective: The prominent ear is that which forms an angle of over 30 degrees with the head. It can be caused by an overdevelopment of the conchal cartilage or by the incomplete folding of the anti-helix. This deformity, that seems to cause psychological and/or social problems in school-age children, can be surgically corrected by otoplasty. This paper aims to evaluate the psychological consequences of this deformity in children with prominent ears.

Methods: 17 children from both sexes were evaluated, during the pre-surgery phase of the otoplasty, by means of interviews and psychological tests, which were submitted to an analytical descriptive statistic.

Results: To have a prominent ear for 88.2% of the participants is related to an emotional aspect, causing shame, uncomfort and sadness and causes various disturbances to the carriers, which are frequently made fun at.

Conclusions: This study confirms that prominent ears cause a significant visual impact, compromising these children's self-image, hence interfering in their emotional development and in the establishment of their school and friendship.

REFERENCES:

1. Sociedade Brasileira de Cirurgia Plastica - SBPC. Guia Informativo da SBPC: Aspectos Psicológi cos em Cirurgia Plástica. Disponível em: http://www.cirurgiaplastica.org.br, acessado em 19/07/2005.
2. Buck, J. N. – H-T-P: Casa-Árvore-Pessoa. Técnica Projetiva de Desenho. Manual e Guia de Interpretação. Vetor. São Paulo, 2002.

Poster 151 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

PSYCHODYNAMISM OF PARENTS OF CHILDREN WITH SERIOUS ASTHMA

Wilze L. Bruscato, Ph.D., *Psychology Services, Santa Casa de Sao Paulo, Brazil, Rua Cesario Motta Jr., #112, Sao Paulo, Brazil 01221-900*; Adriana Fregonese, M.Psy.; Wilma Forte, D.M.

SUMMARY:

Objective: Asthma is a chronic disease that affects 10% of the Brazilian population and is a public heath problem, resulting in high social cost due to hospitalizations, school absence, partial or total inability to work. It has a multifarious etiology, in which organic and/or hereditary factors join environmental and psychological ones. Asthma is a chronic childhood disease that brings many issues to family life, interfering in child's and parents' routine. There are many hospitalizations, besides the need of alimentation, hygiene and sports practice control. The clinical treatment provided by the heath team is affected by parents' adhesion problems, especially by the asthmatic children's mothers. Parents' emotional issues jeopardize the children's maturation process, blocking medical and psychological treatments. Both parents and society impede the asthmatic to become independent, and many children feel comfortable in that place, allowing parents to think, act and decide everything for them, maintaining a dependent relationship that

may last for their whole life. Considering those aspects, this research purpose is to investigate motherhood and fatherhood meaning, besides the association between the parents' psychodynamism and children's respiratory allergy.

Methods: The investigation instruments used were semi-guided interviews and two boards of Thematic Apperception Test (TAT).

Results: Through the analysis of the data and qualitative evaluation it was possible to conclude that both fathers and mothers have difficulty expressing satisfaction or not with conjugal union. Regarding motherhood, it was noticed the permanence of immature and less elaborate conflicts are difficult to solve. They tend to see their children as fragile and provide an exaggerated protection that keep the child attached to them. Most fathers had emotional problems on finding their places as partners and parents. They act as supplying of material resources and keep an affective distance. When the child realizes the parents' weakness, it is possible to achieve everything that is desired, obtaining ''gains'' from the symptom. Parents can also obtain ''gains'' from children's asthma, because the crisis may take parents' attention away from conjugal conflicts, avoiding their facing and solving.

Conclusions: The parents' emotional issues affect the relationship with their children and the asthma assumes a communicative value for the parents-child triad.

REFERENCES:

1. Hartmann, J. B. Gasquez, A. H. – Grupo de Mães e ou Acompanhantes no Sistema de Internação Con junta na Unidade Pediátrica do Hospital Universitário Regional de Maringá. Revista de Psicologia Hospitalar, 7 (1): 35–46, 1997.
2. Sociedade Brasileira de Pediatria - SBP – Guia de Atuação Frente a Maus-tratos na Infância e na Adolescência: Orientações para Pediatras e Demais Profissionais da Saúde. Fiocruz. Rio de Janeiro, 2002.

Poster 152 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

DOES COMBAT INCREASE THE RISK OF DEPRESSION FOLLOWING TRAUMATIC BRAIN INJURY?

Clark Clark, D.O., *Psychiatrist, Behavioral Medicine Division, George Leonard Wood Army Community Hospital, 126 Missouri Avenue, Fort Leonard Wood, MO 65473*; Elisabeth Martin, M.S.N.

SUMMARY:

Depression is a well documented sequelae of traumatic brain inury. There is evidence to suggest that exposure to combat may also increase the risk of depression. However, it is unknown if the risk of depression will be increased in combat veterans who sustained atraumatic brain injury in combat. The rates of depression in active duty service members who sustained a TBI in combat were compared to the rates of depression in active duty service members who did not sustain a TBI in combat. Future areas of research, clinical concerns, possible protective factors are highlighted. This is a preliminary study.

REFERENCES:

1. Jorge, R.E., et.al., Major depression following traumatic brain injury. Arch Gen Psychiatry, 2004. 61 (1): p. 42–50.
2. Hoge et.al, Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care. NEJM, Vol 351:13–22.

Poster 153 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

INFLUENCE OF CONCURRENT METABOLIC DISORDERS UPON THE OUTCOME OF TREATMENT FOR ACUTE MANIA

Dale A. D'Mello, M.D., *Associate Professor, Department of Psychiatry, Michigan State University, St. Lawrence-Sparrow Hospital, 1210 W. Saginaw, Lansing, MI 48917*

SUMMARY:

Metabolic disorders such as obesity, dyslipidemia and diabetes are more common in patients with bipolar disorder than others. The influence of these conditions upon treatment outcomes remains to be elucidated.

Objectives: The purpose of the present study was to examine clinical correlates of concurrrent metabolic disorders in a cohort of patients hospitalized for acute mania.

Method: We recruited patients who were consecutively admitted to an adult psychiatric unit in mid-Michigan during calendar years 2004–2006 with acute mania. We gathered demographic and health related information from the hospital medical records. We then examined statistical correlations between metabolic variables (body mass index, fasting plasma glucose, lipid parameters, and blood pressure), levels of psychopathology (YMRS: Young Mania Rating Scale) and treatment outcomes (length of hospital stay).

Results: Seventy-three patients were included in the study: 64% were either overweight or obese, 70% had dyslipidemia, 79% were prehypertensive or hypertensive, 43% were prediabetic or diabetic, and 48% met

modified diagnostic criteria for metabolic syndrome. The presence of metabolic syndrome and fasting plasma glucose levels predicted longer subsequent hospital stays (Pearson correlation co-efficient r=0.553, p=0.002).

Conclusions: In addition to the burden of physical symptoms, concurrent metabolic disorders appear to have an adverse influence upon the treatment outcome of bipolar disorder.

REFERENCES:

1. Carney CP, Jones LE: Medical comorbidity in women and men with bipolar disorders: a population-based controlled study. Psychosom Med 2006; 68 (5):684–691.
2. Thompson WK, Kupfer DJ, Fagiolini A, Scott JA, Frank E: Prevalence and clinical correlates of medical comorbidities in patients with bipolar I disorder: analysis of acute-phase data from a randomized controlled trial. J Clin Psychiatry. 2006 May;67(5): 783–8.

Poster 154 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

EFFICACY AND SAFETY OF LISDEXAMFETAMINE DIMESYLATE IN GIRLS AGED 6–12 YEARS OLD WITH ADHD: A SECONDARY ANALYSIS

Supported by Shire Pharmaceuticals, Inc.

Michael Greenbaum, M.D., *Medical Director and President, Capstone Clinical Research, 1117 S. Milwaukee Avenue, B7, Libertyville, IL 60047-8222*; Suma Krishnan, M.S.; Yuxin Zhang, Ph.D.; Robert L. Findling, M.D.; Joseph Biederman, M.D.

SUMMARY:

Objectives: To evaluate LDX efficacy and safety in girls aged 6 to 12 years with ADHD.

Methods: Boys and girls aged 6 to 12 years with ADHD enrolled in this phase III, randomized, double-blind, parallel-group study. Subjects were randomized 1:1:1:1 to 4 weeks of placebo or 30, 50, or 70 mg/d LDX. The primary efficacy outcome was the ADHD Rating Scale (ADHD-RS). Safety measurements included assessments of adverse events (AEs), vital signs, laboratory evaluations, and electrocardiograms.

Results: Of 290 subjects, 72, 71, 74, and 73 were randomized to placebo, 30, 50, or 70 mg/d LDX, respectively. Of these groups, 22, 18, 27, and 21, respectively, were girls (n=88). At endpoint, LS mean (±SE) changes in ADHD-RS for girls (ITT population) in the placebo, 30, 50, and 70 mg/d LDX groups were 8.13 (±3.14), −18.98 (±3.33), −18.81 (±2.88), and −24.80 (±3.27), respectively. Improvement was statistically significant for each LDX dose (P<.05 vs. placebo). Most treatment-emergent AEs were mild to moderate. Commonly reported AEs included decreased appetite, insomnia, headache, and upper abdominal pain. Eleven girls discontinued due to AEs.

Conclusions: LDX treatment significantly improved ADHD symptoms in girls and was well tolerated.

REFERENCES:

1. Biederman J, Krishnan S, Zhang Y, McGough JJ, Findling RL: Efficacy and tolerability of lisdexamfetamine dimesylate (NRP-104) in children with attention-deficit/hyperactivity disorder: a phase III, randomized, multicenter, double-blind, parallel-group study. Clin Ther 2007; 29:450–463.
2. Biederman J, Boellner SW, Childress A, Lopez FA, Krishnan S, Zhang Y: Lisdexamfetamine mesylate and mixed amphetamine salts extended-release in children with ADHD: a double-blind, placebo-controlled, crossover analog classroom study (in press). Biol Psychiatry.

Poster 155 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

THE PREVALENCE OF PROBLEMATIC GAMBLING AMONG U.S. MILITARY VETERANS

Robert W. Hierholzer, M.D., *Associate Chief of Staff, Research and Education, VA-Central California Health Care System, 2615 East Clinton Avenue, Fresno, CA 93703*; Holly Vu; Ronna Mallios, M.P.H.

SUMMARY:

Pathological gambling (PG) is associated with a host of adverse social and medical consequences, and psychiatric comorbidities. The vast majority of Americans who gamble do not develop PG. Potential risk factors explaining this differential vulnerability have been proposed. Some studies have found PG to be increased among those with combat related Post-Traumatic Stress Disorder (PTSD), suggesting it might be one such risk factor. As a first step toward elucidating connections between PG and PTSD, this pilot study was undertaken to yield an estimate of the one-year prevalence of pathological and problem gambling among U.S. combat veterans with PTSD, utilizing the South Oaks Gambling Screen (SOGS) and a locally developed questionnaire assessing demographics and distress related to study participation. The 120 participants in this anonymous study were mostly male Vietnam Veterans (80%). Twenty percent of participants were classified as pathological gamblers by the SOGS and another 4.2% classified as "problem gamblers" - rates much higher than accepted estimates for the U.S. population overall. There

was a strong correlation between participant distress and problem gambling status. The implications for identifying, investigating and treating PG among veterans are discussed, as are the limitations of this study.

REFERENCES:

1. O'Toole BI, Marshall RP, Schureck RJ, Dobson M: Post-traumatic stress disorder and comorbidity in Australian Vietnam veterans: risk factors, chronicity and combat. Australian and New Zealand Journal of Psychiatry 1998; 32:32–42.
2. Welte J, Barnes G, Wieczorek W, Tidwell MC, Parker J: Alcohol and gambling pathology among U.S. adults: prevalence, demographic patterns and comorbidity. Journal of Studies on Alcohol 2001; 62:706–712.

Poster 156 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

DEPRESSION: A RISK FACTOR OF HIGH-RISK SEXUAL BEHAVIORS IN LATE MIDDLE AGE AND OLDER HIV SEROPOSITIVE ADULTS

Lourdes T. Illa, M.D., *Assistant Professor, Department of Psychiatry, University of Miami, 1695 N.W. 9th Avenue, Suite 1404-A, Miami, FL 33136*; Marisa Echenique, M.S.; Gilbert Saint-Jean, M.D.; Mario J. Sanchez-Martinez, M.D.; Victoria Bustamante-Avellaned, Psy.D.; Allan Rodriquez, M.D.

SUMMARY:

Objective: Our study's objectives are to examine the sexual behaviors of HIV positive older adults and identify potential psychological factors associated with transmission behaviors.

Methods: As part of a larger HRSA funded multi-site study examining secondary HIV prevention, 210 HIV positive individuals 45 and over reporting vaginal or anal sex within the past 6 months were recruited from primary care clinics and assessed in terms of sexual behaviors, HIV knowledge and psychosocial factors.

Results: Our sample scored higher on average than both the adult and geriatric normed groups on the Profile of Mood States (POMS) total mood scale and the depression, tension, anger and confusion subscales. Almost one-fifth reported inconsistent condom use and 33% had multiple sexual partners during the previous six months. Sixty percent engaged in vaginal or anal sex with negative/unknown serostatus partners, and of these, 17.3% reported not using condoms consistently. Negative mood was significantly associated with inconsistent condom use.

Conclusions: Older HIV positive adults engage in high-risk sexual behaviors and may experience higher rates of depressive symptoms, which could be a predictor of high-risk transmission behaviors.

REFERENCES:

1. McNair DM, Lorr M, and Droppleman LF. (1981). Profile of mood states (POMS) manual. San Diego, CA: Educational and Industrial Testing Service.
2. Orel NA, Spence M, and Steele J. (2005). Getting the message out to older adults: Effective HIV health education risk reduction publications. Journal of Applied Gerontology, 24, 490–508.

Poster 157 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

REVISITING THE COST-EFFECTIVENESS OF BIPOLAR DISORDER INTERVENTIONS

Jane Kim, Ph.D., *Assistant Professor, Health Policy and Management, Harvard School of Public Health, 718 Huntington Avenue, Boston, MA 02115*; Dan J. Siskind, M.D., M.P.H.

SUMMARY:

Objectives: Mathematical models are increasingly being used to evaluate the cost-effectiveness of mental health interventions and to inform health decisions in many settings. However, very few models exist that focus on interventions for bipolar disorder; those that do exist rely on simplified model structures based on only a few health states.

Methods: We developed a more detailed Markov state-transition model of bipolar disorder that capitalizes on the availability of newer data on the natural history and clinical course of bipolar disorder. We utilized this model to evaluate the cost-effectiveness of bipolar disorder treatment (including lithium, anti-convulsant, antipsychotic, and adjuvant antidepressant medications) and compared results to previous analyses in different world regions.

Results: Using our enhanced model, we found that estimates of cost-effectiveness ratios were consistently 15–20% lower than those from previous model-based economic evaluations, suggesting that inclusion of clinically relevant characteristics of bipolar disorder in models may be important when making policy decisions of treatment at the population level.

Conclusions: Previous models of bipolar disorder may have underestimated the cost-effectiveness of interventions in both developed and developing countries. We demonstrate the flexibility of an enhanced model of

bipolar disorder and provide revised estimates of cost-effectiveness to aid in decision-making.

REFERENCES:

1. Lam DH, Watkins ER, Hayward P, et.al. Cognitive therapy for bipolar illness: a pilot study of relapse prevention. Cognitive Therapy Research 2000;24: 503–520.
2. Colon F, Vieta E, Reinares M, et.al. Psychoeducation efficacy in bipolar disorders: beyond compliance enhancement. J Clin Psychiatry 2003;64:1001–1105.

Poster 158 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

IS PAIN RELATED TO UNDER-DIAGNOSIS OF DEPRESSION AMONG PRIMARY CARE PATIENTS?

Supported by Eli Lilly and Company

Kathryn Magruder, Ph.D., M.P.H., *Associate Professor, Psychiatry and Behavioral Sciences, Medical University of South Carolina, 109 Bee Street, Charleston, SC 29401*; Rebecca Knapp, Ph.D.; Rebecca Robinson, M.S.C.

SUMMARY:

Pain is a well known correlate of depression in medical patients. We examined if pain is also a factor in physicians' recognition of depression in primary care. Subjects were 8 randomly selected primary care patients drawn from four VA hospitals in the Southeast who were administered a structured psychiatric assessment (Mini International Neuropsychiatric Interview or MINI) and the SF-36. MDD and dysthymia were assessed using the MINI; all medical and psychiatric ICD9 diagnoses (including MDD, depression NOS, and dysthymia) were taken from electronic medical records for a 24-month period (+/−12 months from the clinic interview); self-rated pain was assessed with the SF-36 bodily pain subscale. Taking only those who were MINI positive for MDD or dysthymia (n=191), patients were classified into two categories based on congruence with ICD9 chart diagnoses: correctly diagnosed (n=100) (MINI positive, ICD9 positive) and under-diagnosed (n=91) (MINI positive, ICD9 negative). Analyses compared patients who were under-diagnosed with correctly diagnosed patients. Logistic regression analyses showed that after adjustment for age, race, and gender, higher self-reported pain was significantly related to correct recognition of depression (p=.008). Males (OR=2.6; CI's 1.2–5.7) and minorities (OR=2.2; CI's 1.1–4.3) were more likely to be under-recognized. Patients with >1 diagnoses related to chest pain (OR=3.0, 1.3–7.0) or neurological pain (OR=3.5, 1.1–11.6) were significantly more likely to be correctly diagnosed for depression; however, these relationships became nonsignificant in the presence of self-reported bodily pain which remained significant. Back, musculoskeletal, and other pain-related diagnoses were not significantly related to depression recognition. In summary and contrary to earlier studies, patients with pain were more apt to be correctly diagnosed as depressed. Self-reported pain was a more robust predictor than pain-related diagnoses. Providers should carefully evaluate patients for depression – especially males, minorities, and those who report better general health status, including better functioning related to pain.

REFERENCES:

1. Arnow BA, Hunkeler EM, Blasey CM, Lee J, Constantino MJ, Fireman B, Kraemer HC, Dea R, Robinson R, and Hayward C. Comorbid Depression, Chronic Pain, and Disability in Primary Care. Psychosomatic Medicine 68:262–268 (2006).
2. Karlsson H, Joukamaa M, Lehtinen V. Differences between patients with identified and not identified psychiatric disorders in primary care. Acta Psychiatrica Scandinavica 2000; 102:354–8.

Poster 159 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

EFFICACY AND SAFETY OF LISDEXAMFETAMINE DIMESYLATE IN NON-CAUCASIAN CHILDREN AGED 6–12 YEARS OLD WITH ADHD: A SECONDARY ANALYSIS

Supported by Shire Pharmaceuticals, Inc.

Michael McManus, M.D., *Psychiatric Centers at San Diego, 1550 Hotel Circle North, #270, San Diego, CA 92108*; Suma Krishnan, M.S.; Yuxin Zhang, Ph.D.; Robert L. Findling, M.D.; Joseph Biederman, M.D.

SUMMARY:

Objectives: Evaluate the efficacy and safety of lisdexamfetamine dimesylate (LDX) in non-Caucasian children aged 6 to 12 years with attention-deficit/hyperactivity disorder (ADHD).

Methods: A phase III, randomized, double-blind, parallel-group trial with ADHD children (*DSM-IV*-TR® criteria) of diverse ethnicities. Following screening and washout, subjects were randomized in a 1:1:1:1 ratio to 4 weeks of placebo or 30, 50, or 70 mg/d LDX. Primary efficacy measure: ADHD Rating Scale (ADHD-RS). Safety: adverse events (AEs), physical examinations, laboratory measurements, and electrocardiograms.

Results: Subjects (N=290) were randomized, 72, 71, 74, and 73 to placebo, 30, 50, or 70 mg/d LDX, respectively. Of these, 29, 34, 40, and 32, respectively, were

non-Caucasian (n=135). At endpoint, LS mean (±SE) changes in ADHD-RS for placebo, 30, 50, and 70 mg/d LDX were −10.12 (±2.81), −18.−53 (±2.51), −20.21 (±2.43), and −25.13 (±2.67), respectively. Improvement in ADHD-RS for non-Caucasians was significant for each LDX dose (P<.05 per model-based t-test). LDX was well tolerated. Most treatment-emergent AEs were mild to moderate, occurring during the first week of treatment. The most common AEs were decreased appetite, insomnia, and headache. There were 10 discontinuations due to AEs.

Conclusions: LDX significantly improved ADHD symptoms in non-Caucasian children and was well tolerated.

REFERENCES:

1. Biederman J, Krishnan S, Zhang Y, McGough JJ, Findling RL: Efficacy and tolerability of lisdexamfetamine dimesylate (NRP-104) in children with attention-deficit/hyperactivity disorder: a phase III, randomized, multicenter, double-blind, parallel-group study. Clin Ther. 2007; 29:450–463.
2. Biederman J, Boellner SW, Childress A, Lopez FA, Krishnan S, Zhang Y: Lisdexamfetamine mesylate and mixed amphetamine salts extended-release in children with ADHD: a double-blind, placebo-controlled, crossover analog classroom study. Biol Psychiatry 2007. In press.

Poster 160 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

THE TARGETED TREATMENT DEPRESSION INVENTORY: A ONE-YEAR, NATIONAL PILOT STUDY

Richard J. Metzner, M.D., *Clinical Professor of Psychiatry and Biobehavioral Sciences, UCLA, 25 Cindercone Circle, Sedona, AZ 86336*; Andrew P. Ho, M.D.

SUMMARY:

The TTDI is the first depression rating scale designed to guide antidepressant selection. It utilizes an M score to quantify the need for modulation with serotonergic agents, an A score to measure the need for activation with catecholaminergic medications and a D score to represent the level of total depression comparable to the scores of other depression tests. In September 2005, the TTDI was made available to health professionals online at no cost. Scoring was done using a web-based program that permitted creation of a centralized research database. As of December 2006, the instrument had been used in 50 practice locations across the United States with 361 patients for a total of 471 administrations. The Zung Self-rating Depression Scale was also offered for scoring online and was concurrently administered with the TTDI on 94 occasions. The first 315 TTDI test administrations were evaluated using the Statistical Package for the Social Sciences (SPSS). The results indicated that both the M and A scales had reliabilities of .777 (standardized Cronbach alpha). Analysis using a three component plot rotated in space revealed the M and A scales to cluster separately as two distinct factors. Interestingly, items related to appetite and sleep did not sort as consistently as other indicators of demodulation and deactivation. Correlation between the Zung scores and all three TTDI measures: M (r=.57), A (r= .48), and D (r=.64) were significant at the P<.01 level. We conclude that the TTDI scales are internally reliable measures of two discrete symptom clusters which separately and together demonstrate convergent validity. Preliminary indications that TTDI scores may also evidence predictive validity for optimizing antidepressant treatment are being further investigated.

REFERENCES:

1. Balzac, F.:Taking aim at the targeted treatment of depression, Neuropsychiatry Reviews July 2005;6: 6.
2. Clark LA,Watson D: Tripartite model of anxiety and depression: psychometric evidence and taxonomic implications. J Abnormal Psychol 1991; 100:3–336.

Poster 161 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

THE IMPACT OF DEPRESSION ON THE QUALITY OF LIFE OF DEPRESSED ELDERLY INPATIENTS

Susan Ryan, C.T.R.S., M.Ed., *Certified Therapeutic Recreation Specialist, Department Psychiatry and Psychology, Mayo Clinic College of Medicine, 200 1st Street, S.W., Rochester, MN 55905*; Maria I. Lapid, M.D.; Katherine Piderman, Ph.D.; Kristin J. Somers, M.D.; Susanna Stevens, M.S.; Teresa A. Rummans, M.D.

SUMMARY:

Purpose: To determine how changes in depression during psychiatric hospitalization are associated with the quality of life (QOL) of depressed elderly patients.

Methodology: This Mayo IRB-approved prospective study recruited geropsychiatric inpatients 65 years and older who were depressed, had MMSE > 18/30, and adequate communication skills. Surveys were completed upon admission and discharge to measure depression (HamD), QOL (SF-36, LASA), and cognitive function (MMSE, EXIT 25). Spearman correlations and Wilcoxon signed rank tests were used to assess relationships

among variables and changes in measures during treatment.

Results: The 24 subjects who completed the study were of mean age 73, 67% female, 67% married, and 87% at least high school educated. Discharge assessments showed reduction in HamD (p<.0001), increase in LASA overall QOL (p=0.0073), and increase in each of the SF-36 QOL domains (all p<0.035). Correlations between the changes in depression and QOL (LASA overall QOL: - .40, p=0.0537; SF-36 general health scale: - .46, p=0.0270) were significant.

Conclusion: There was improvement of both depression and QOL at the end of hospitalization. Improvement of depression is associated with improvement of QOL. Further studies are needed to develop interventions to improve QOL in geriatric depression.

REFERENCES:

1. Shmuely, Y., et.al., Predictors of Improvement in Health-Related Quality of Life Among Elderly Patients With Depression. International Psychogeriatrics, 2001. 13(1): p. 63–73.
2. Unutzer, J., et.al., Quality Adjusted Life Years in Older Adults With Depressive Symptoms and Chronic Medical Disorders. International Psychogeriatrics, 2000. 12(1): p. 15–33.

Poster 162 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

PROVIDING QUALITY CARE FOR LONG-TERM RESIDENTS OF STATE INSTITUTIONS: A CONTINUUM OF CARE FOR HIGH-END USERS FROM THE YEARS 2003–2006

Anasuya Salem, M.D., M.P.H., *Resident, Department of Psychiatry, Delaware Psychiatry Residency Program, 1901 N. Dupont Highway, New Castle, DE 19720*; Carol Kuprevich, Ed.D.

SUMMARY:

Background: The High End User is an intensive system of case management that integrates multiple resources. Individuals in HEUP are pre-identified by the unit that monitors all involuntarily committed patient admissions in Delaware hospitals. Acute psychiatric hospitalization is pre-authorized for consumers in the HEUP for admission to the public funded hospital instead of frequent "short" stays in other acute inpatient settings.

Methods: Descriptive epidemiological study was done to justify the need for the project. Total number of subjects included in the study is 103. Study included admission data from 2003–2006. Inclusion Criteria: 4 or more hospitalizations within any 12 month period; patients with 30 days of inpatient care within any 12 month; 3 admissions within any 90-day period; aged 18–69+ years; and assigned to an intensive case management program or community based acute outpatient day treatment program.

Results: The findings of the project are: After these patients were placed under high end user system, there is 10% reduction in inpatient treatment rate, 12% reduction in subsequent treatment episodes, 4% reduction in the average length of stay, and 44% increase in receiving treatment from provider 2 (provider 2 = High End User Unit).

Conclusion: This study supports that there is a need for this system, which will provide improvement in performance by observing effectiveness of integrated treatment planning involving the community treatment team and the public state psychiatric hospital.

REFERENCES:

1. Nierman P, Lyons J. State mental health policy: shifting resources to the community. Psychiatric Services 52:1157–1159, September 2004.
2. Wolff N, Stuber J. State mental hospitals and their host communities: The origins of hostile public reactions. Journal of Behavioral Health Services and Research, Vol 29:#3, August 2005, 1094–3412.

Poster 163 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

VALPROATE FOR BIPOLAR DISORDER AND CO-MORBID SUBSTANCE ABUSE: A 24-WEEK, OPEN LABEL TRIAL

Supported by Abbott Laboratories

S. Pirzada Sattar, M.D., *Assistant Professor of Psychiatry, Creighton University/Omaha VAMC, 4101 Woolworth Avenue, Omaha, NE 68105*

SUMMARY:

Background: Bipolar disorder is commonly complicated by comorbid substance dependence. Little is known about treatment of this important subpopulation of patients with bipolar disorder. Some preliminary evidence suggests that valproate, which is an approved treatment of acute bipolar mania, may also reduce substance use, however, most of these studies were conducted over a 12 week period. Long-term studies to test the efficacy of this medication have not been conducted. The following is a 24-week pilot study exploring the use of valproate in patients with bipolar disorder and comorbid alcohol and stimulant dependence.

Method: 20 patients were enrolled with bipolar disorder and concurrent substance dependence (10 alcohol, 10 stimulant dependence), as defined by *DSM-IV*-TR.

All participants were treated with valproate in an open-label, non-blinded trial for a period of 24-weeks. Of the 20 participants, 20 completed the study. Subjects were followed for a mean of weeks. Ratings included measures of affective state (Young Mania Rating Scale), as well as substance use (Time-Line Follow-Back).

Results: Patients tolerated valproate well with minimal reports of side effects and no liver toxicity or increase in liver function tests noted. While not statistically significant, subjects evidenced improvement in their mania (Young Mania Rating Scale score 17.2 vs. 8.6, p = .06), and a decrease in number of days of substance use (TLFB number of days used 17.1 vs. 9.7 days, p = .07), as compared with the month before valproate treatment.

Conclusion: While limited by the open-label, non-blinded nature of the design, this study provides evidence that suggests the efficacy of valproate in the acute treatment of bipolar episodes and concomitant substance dependence over 6 months of treatment. The medication was well tolerated, and no unacceptable elevations in liver function tests were seen.

REFERENCES:

1. Albanese MJ, Clodfelter RC Jr, Khantzian EJ. Divalproex sodium in substance abusers with mood disorder. J Clin Psychiatry. 2000 Dec; 61(12):9–21.
2. Myrick H, Brady KT. The use of divalproex in the treatment of addictive disorders. Psychopharmacol Bull. 2003;37 Suppl 2:89–97.

Poster 164 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

OXIDATIVE IMBALANCE IN ADULT ADHD

Salih Selek, M.D., *Department of Psychiatry, Sahinbey Research Hospital, Gaziantep University, Hastanesi Psikiyatri, Gaziantep, Turkey 27310*; Haluk A. Savas, M.D.; Hasan Gergerlioglu, M.D.; Mahmut Bulut, M.D.; Haci Yilmaz, M.D.

SUMMARY:

Objective: There are few studies evaluating the biochemical basis of Adult Attention Deficit /Hyperactivity Disorder (A-ADHD). In the present study, we evaluated whether nitric oxide (NO), an oxidant, level and superoxide dismutase (SOD), an antioxidant, activity are associated with A-ADHD or not. This study also aims to evaluate the NO levels and SOD activities, which were already measured and found to be associated in other psychiatric disorders, in A-ADHD and hopes to find some clues underlining the biological basis of the disease.

Method: Twenty A-ADHD patients from Gaziantep University Sahinbey Research Hospital, Psychiatry Clinic, diagnosed according to The Turkish version of Adult ADD/ADHD DSM IV- Based Diagnostic Screening and Rating Scale by two psychiatrists (H.A.S. and S.S.), and twenty-one healthy volunteer controls were included. Blood samples were collected, NO levels and SOD activities were measured.

Results: The mean NO levels in patients (181.39 ± 35.85 μmol/L) were significantly higher than those of controls (40.14± 7.71 μmol/L) and SOD activity of patients (7.00± 1.34 U/L) was significantly lower than controls (11.18 ± 1.31 U/L) (t= 17.64, df= 39, p< 0.01 and t= −10.09, df= 39, p< 0.01 respectively).

Conclusions: Remarkable high levels of oxidant NO, and low SOD activities suggest an oxidative imbalance in A-ADHD. This is the first study evaluating the oxidative metabolism in A-ADHD. Our findings may pioneer the further clinical enzymology and biochemical studies on that disorder.

REFERENCES:

1. Faraone SV: Advances in the genetics and neurobiology of attention deficit hyperactivity disorder. Biological Psychiatry. 2006;60:1025–7.
2. Aspide R, Gironi Carnevale UA, Sergeant JA, Sadile AG: Non-selective attention and nitric oxide in putative animal models of Attention-Deficit Hyperactivity Disorder. Behavioural Brain Research 1998;95:123–33.

Poster 165 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

TRANSCRANIAL MAGNETIC STIMULATION IN THE ACUTE TREATMENT OF MAJOR DEPRESSION: IMPROVEMENTS IN FUNCTIONAL STATUS AND QUALITY OF LIFE

Supported by Neuronetics Inc.

Brent Solvason, M.D., Ph.D., *Assistant Professor, Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305*; Mustafa Husain, M.D.; Paul Fitzgerald, M.D.; Peter Rosenquist, M.D.; W. Vaughn McCall, M.D.; Sarah H. Lisanby, M.D.

SUMMARY:

Objective: Clinical outcomes from antidepressant treatment on measures of functional status and quality of life are increasingly recognized as critically important since they inform whether any symptom change is associated with meaningful change in function and life satisfaction. Transcranial magnetic stimulation (TMS) is effective in the treatment of major depression. We describe the functional status and quality of life outcomes from acute treatment with TMS.

Methods: 301 medication-free patients were randomized 1:1 to treatment with active or sham TMS in a 6 week, parallel group, double-blind, multisite, controlled trial, with the Neuronetics Model 2100 System. Treatment parameters were optimized in a fixed, maximum feasible dose design. TMS was administered 5 x/week at 10 pulses/second, 4 seconds on/26 seconds off, 120% of motor threshold, for a total of 3000 pulses/session. Symptom efficacy was evaluated with the MADRS, HAMD24 and HAMD17, and has been previously described. Functional status was assessed using the Medical Outcomes Study-36 Item Short Form (v1) at baseline, 4 and 6 weeks of acute treatment. Quality of life was assessed using the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) at the same time points.

Results: After 4 weeks of treatment, patients assigned to active TMS showed a statistically superior outcome compared to sham on both the General Health (P = 0.049) and Mental Health (P = 0.006) subscales of the SF-36. After 6 weeks, active TMS treatment continued to show statistically significant benefit on the same subscales, and additionally on the Role-Emotional (P = 0.044) subscales, with a trend on the Vitality (P = 0.081) subscale. The Q-LES-Q showed statistically significant superiority in active TMS at 6 weeks of treatment (P = 0.035).

Conclusions: Acute treatment with TMS improves functional status and quality of life outcomes in patients with major depression.

REFERENCES:

1. O'Reardon J, Solvason HB, Janicak PG, et.al. Efficacy and safety of transcranial magnetic stimulation therapy in the acute treatment of unipolar major depression. In press Biological Psychiatry 4/2007.
2. Sampson S, Solvason HB, Husain M. Envisioning Transcranial Magnetic Stimulation as a Clinical Treatment Option for Depression. Psychiatric Ann 37(3): 189–196.

Poster 166 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

DEPRESSION AND ANXIETY IN THE UNITED STATES: FINDINGS FROM THE 2006 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

Tara W. Strine, M.P.H., *Epidemiologist, Division of Adult and Community Health, Department of Behavioral Health Sciences, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Bufford Highway N.E. MS K-67, Atlanta, GA 30341*; Ali Mokdad, Ph.D.; Lina Balluz, D.Sc.

SUMMARY:

Depression and anxiety are two major causes of morbidity and mortality in the U.S. and are associated with impaired health-related quality of life, as well as excess disability and chronic disease. The purpose of this poster is to examine the associations among depression and anxiety and cardiovascular disease, diabetes, asthma, and adverse health behaviors for U.S. community-dwelling adults using the 2006 Behavior Risk Factor Surveillance System. Data was available for 217,379 participants in 38 states, DC, and two territories. Current depression was defined as a score of =10 on the Patient Health Questionnaire 8. The prevalence of current depression was 8.7%, lifetime diagnosis of depression was 15.7%, and lifetime diagnosis of anxiety was 11.3%. West Virginia had the highest rate of current depression (13.7%) and lifetime diagnosis of anxiety (17.2%) and Arkansas had the highest rate of lifetime diagnosis of depression (21.3%). Cardiovascular disease, diabetes, asthma, smoking, physical inactivity, obesity and heavy drinking were all significantly associated with current depression, and lifetime diagnosis of anxiety or depression (chi-square <0.001). Given the associations between mental health, physical health, and adverse health behaviors, examination of mental health should be an integral component of overall health care.

REFERENCES:

1. Kroenke K, Spitzer RL. The PHQ-9: A new depression diagnostic and severity measure. Psychiatric Ann. 2002;32(9):1–7.
2. Martin A, Rief W, Klaiberg A, Braehler E. Validity of the Brief Patient Health Questionnaire Mood Scale (PHQ-9) in the general population. Gen Hospital Psychiatry. Jan-Feb 2006;28(1):71–77.

Poster 167 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

ADOLESCENT SUICIDE IN QUEBEC FROM 1999 TO 2004: REGIONAL DIFFERENCES AND CORRELATIONS WITH SECOND-GENERATION ANTIDEPRESSANT PRESCRIPTIONS

Valerie Trottier-Hebert, M.D., *Resident, Department of Psychiatry, University of Sherbrooke, 4227 Laval, Montreal, QC, Canada H2W 2J6*; Pierre Gagne, M.D.; Marie-Claude Cote, M.D

SUMMARY:

Objectives: Quebec has one of the highest rates of adolescent suicide in the world. Moreover, it appears that the vast majority of its teenage suicide completers are Canadians of French origin, although the highest incidence is being found in the Inuit (Native Canadians) communities. Adolescent suicide risk factors already recognized in the literature include older age, male gender, mood disorders, previous suicide attempts, poor parent-child communication and substance abuse. The main goals of this retrospective study were to: 1.) Identify socio-demographical, clinical and psychosocial factors associated with suicide within a cohort of Quebec adolescents and then to compare those factors according to their region, and; 2.) Study the correlation between regional suicide rates and regional second-generation antidepressant prescriptions in 2004.

Methods: All (n = 480) files on suicides committed by individuals 19 years and younger in a six-year period (1999–2004) were reviewed at the Quebec Coroner Office. Socio-demographical, clinical and psychosocial variables were used to compare suicide completers according to their region. Antidepressant prescriptions data for 2004 was obtained from IMS Health Canada.

Results: The correlation established between regional suicide rates and regional antidepressant prescriptions was not statistically significant. However, striking regional differences were found and will be further discussed.

REFERENCES:

1. Bridge JA. et.al., Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment, JAMA, April 2007, Vol 297, no 15.
2. King RA, Apter A, Suicide in Children and Adolescents, Cambridge University Press, 2003.

Poster 168 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

COMORBID DEPRESSION AND SUBSTANCE USE DISORDER

Akihito Uezato, M.D., *Resident, Department of Psychiatry and Behavioral Neurobiology, University of Alabama at Birmingham, 1700 7th Avenue, South, Birmingham, AL 35294*; Lori L. Davis, M.D.; Elizabeth Frazier, M.A.

SUMMARY:

Objective: To review the literature on the comorbidity of major depressive disorder and substance use disorder (MDD+SUD).

Method: A MEDLINE search for articles pertaining to primary MDD and concurrent SUD was conducted for this descriptive review.

Result: In treatment-seeking patients with MDD, the prevalence of concurrent SUD (excluding caffeine and nicotine) ranges from 8.6 to 25%, and lifetime prevalence of SUD is 30 to 42.8%. Compared to MDD patients, those with MDD+SUD tend to be more severely depressed and have a higher number of previous suicide attempts. Based on recent prospective studies, the MDD+SUD patients are more likely to be male, divorced or never married, have younger age of onset, and have greater functional impairment. Finally, the treatment outcomes of MDD+SUD are reviewed.

Conclusion: The differential treatment effects based on SUD comorbidity has been understudied, since most MDD patients with SUD are typically excluded from clinical trails of antidepressants. Emerging results of recent studies comparing the outcome of MDD patients with MDD+SUD suggest that there are less differential effects based on comorbidity than previously anticipated by older assumptions from smaller, less methodologically rigorous studies.

REFERENCES:

1. Davis LL, Frazier E, Husain MM, Warden D, Trivedi M, Fava M, Cassano P, McGrath PJ, Balasubramani GK, Wisniewski SR, Rush AJ: Substance use disorder comorbidity in major depressive disorder: a confirmatory analysis of the STAR*D cohort. Am J Addict 2006; 15:278–285.
2. Watkins KE, Paddock SM, Zhang L, Wells KB: Improving care for depression in patients with comorbid substance misuse. Am J Psychiatry 2006; 3: 25–132.

Poster 169 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

QUETIAPINE MONOTHERAPY FOR TREATING DEPRESSIVE EPISODES OF BIPOLAR DISORDER

Supported by AstraZeneca Pharmaceuticals

Richard H. Weisler, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, 700 Spring Forest Road, Suite 125, Raleigh, NC 27609*; Robert Arvekvist, M.S.; Bjorn Paulsson, M.D.

SUMMARY:

Objectives: To evaluate the clinical effectiveness of quetiapine monotherapy for acute depressive episodes of bipolar disorder from two trials (BOLDER I and II).

Methods: Post-hoc evaluation was conducted of 1045 outpatients with bipolar disorder (*DSM-IV*) experiencing depressive episodes combined from two similarly de-

signed, 8-week, double-blind, randomized, placebo-controlled trials of quetiapine monotherapy (fixed doses, 300 or 600 mg/d once daily; with a one-time dose reduction of 100 mg/day permitted after Week 1 for intolerability). The primary efficacy endpoint was mean change from baseline to Week 8 in MADRS total score.

Results: Combined study data demonstrated the efficacy of quetiapine monotherapy for treating depressive episodes in bipolar disorder, with significant ($P<0.001$) improvement in MADRS total score from first assessment at Week 1 (–8.9 for quetiapine 300 mg/d, –8.9 for quetiapine 600 mg/d, –5.3 for placebo) to endpoint at Week 8 (–18.8, –19.2, –12.9, respectively). Quetiapine monotherapy was generally well tolerated. Adverse events associated with quetiapine were dry mouth, sedation, somnolence, and dizziness.

Conclusions: Quetiapine monotherapy demonstrated clinical effectiveness in two pivotal trials for treating depressive episodes in patients with bipolar I and II disorder. Quetiapine is the first FDA approved treatment for bipolar II disorder.

REFERENCES:

1. Calabrese JR, Keck PE Jr, Macfadden W, Minkwitz M, Ketter TA, Weisler RH, Cutler AJ, McCoy R, Wilson E, Mullen J, The BOLDER Study Group: A randomized, double-blind, placebo-controlled trial of quetiapine in the treatment of bipolar I or II depression. Am J Psychiatry 2005; 2:1351–1360.
2. Thase ME, Macfadden W, Weisler RH, Chang W, Paulsson B, Khan A, Calabrese JR, for the BOLDER II Study Group: Efficacy of quetiapine monotherapy in bipolar I and II depression: a double-blind, placebo-controlled study (the BOLDER II study). J Clin Psychopharmacol 2006; 26:600–609.

Poster 170 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

USE OF A BIOLOGICAL MARKER TO AID IN THE DIAGNOSIS OF BIPOLAR I DISORDER AND ADHD

Douglas Woodruff, M.D., *Private Practice, Psychiatry, 4419 Falls Road, Baltimore, MD 21211-1226*; Sharon Murphy, M.D.

SUMMARY:

It has been recognized in the literature since at least 1969 that abnormal regulation of ion distribution and variability in the functioning of the Na,K pump is associated with Bipolar Disorder. While using the membrane potential assay developed by Thiruvengadam and Chandrasekaran to indentify Bipolar I Disorder (BPDI), we were intrigued because the emerging data suggested this membrane potential test is also sensitive to presumed malfunctioning of the Na,K pump in Attention Deficit Hyperactivity Disorder (ADHD). Testing 273 patients, of whom 123 were controls (negative), we found 55 to be BPDI and 95 to be ADHD. Confirmation of a diagnosis was by clinical response to medications appropriate for each diagnosis. The sensitivity of the test was comparable to the PSA test. Assuming our findings are replicable in additional trials, this membrane potential assay is a potent clinical tool for clarifying the differential diagnosis between ADHD and BPDI, as well as between unipolar (noncycling) recurrent depression and the depressive phase of BPDI. This membrane potential assay offers the possibility of reduced theraputic misadventure, which can result from the possibility of clinical uncertainity in differential diagnosis using our current diagnostic criteria.

REFERENCES:

1. Swann A: Neurobiology of Bipolar Depression. In Bipolar Depression, A Comprehensive Guide, edited by El-Mallakh, R & Ghaemi, S., Arlington, VA, American Psychiatric Publishing, Inc., 2006, pp37–68.
2. Thiruvengadam, A: Evaluating the validity of blood-based membrane potential changes for the identification of bipolar disorder I. Journal of Affective Disorders; 2006 JAD-03457.

Poster 171 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

TREATMENT COMPLIANCE OF ADULT MAJOR DEPRESSIVE DISORDER PATIENTS ON ESCITALOPRAM AND CITALOPRAM

Supported by Fortest Research Institute

Eric Wu, Ph.D., *Health Economist, Analysis Group, Inc., 111 Huntington Avenue, 10th Floor, Boston, MA 02199*; Elaine Yang, Ph.D.; Paul Greenberg, M.A.; M. Haim Erder, Ph.D.; Marique Buessing, B.A.

SUMMARY:

Objective: To compare escitalopram and citalopram treatment compliance in adult patients with MDD.

Methods: Patients (=18 years) initiating escitalopram or citalopram were identified in the IHCIS National Managed Care Database (1/03–6/05). Switching and discontinuation rates during the 6 months following therapy initiation were compared using chi-square tests and Cox proportional hazard regressions. For patients discontinuing index therapy without switching, the probability of restarting any 2nd generation antidepressant, the risk of hospitalization and emergency department visit after

discontinuation were compared using Kaplan-Meier survival curve and log-rank tests.

Results: The sample included 10,465 escitalopram and 4,212 citalopram patients. Escitalopram patients were less likely to switch away from index therapy, based on chi-square test (p<0.001) and Cox regression (p<0.001). Chi-square test showed that escitalopram patients were more likely to discontinue index therapy without switching (p=0.011). After adjusting for baseline confounding factors, the difference became statistically insignificant (p=0.113). Of patients discontinuing index therapy without switching, patients discontinuing escitalopram were less likely than patients discontinuing citalopram to restart any 2nd generation antidepressant (p= 0.028) or have an emergency visit (p=0.020).

Conclusion: Compared to patients who initiated citalopram, patients who initiated escitalopram have better treatment compliance, lower probability of restarting any 2nd generation depression treatment, or emergency visits after therapy discontinuation.

REFERENCES:

1. Melartin TK: Continuity is the main challenge in treating major depressive disorder in psychiatric care. J Clin Psychiatry 2005;66:220–227.
2. Colonna L: A randomized, double-blind, 24-week study of escitalopram (10 mg/day) versus citalopram (20 mg/day) in primary care patients with major depressive disorder. Curr Med Res Opin 2005;21:59–68.

Poster 172 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

COMPARING TREATMENT COMPLIANCE AND HOSPITALIZATION OF ELDERLY PATIENTS TREATED WITH ESCITALOPRAM AND CITALOPRAM

Supported by Forest Research Institute

Eric Wu, Ph.D., *Health Economist, Analysis Group, Inc., 111 Huntington Avenue, 10th Floor, Boston, MA 02199*; Elaine Yang, Ph.D.; Paul Greenberg, M.A.; M. Haim Erder, Ph.D.; Marique Buessing, B.A.

SUMMARY:

Objectives: To compare treatment compliance, hospitalization, and health care cost in elderly patients with major depressive disorder (MDD).

Methods: Elderly patients with MDD (=65 years) initiated on escitalopram or citalopram were identified in the IHCIS National Managed Care Database (Jan 2003–June 2005). During the 6-month study, treatment switching and discontinuation rates were compared. Comparisons of health care costs were made, using Wilcoxon rank sum tests, and between-groups in total costs and number of hospitalizations.

Results: Compared with citalopram patients (n=232), escitalopram patients (n=459) were less likely to switch to another treatment (Chi-square test: P =.010; Cox regression: p=.001). Discontinuation rates were similar between groups. Escitalopram patients, given discontinuation, were less likely to restart a 2nd generation antidepressant (P =.044) or use inpatient service (P =.045). Escitalopram patients incurred less cost than citalopram patients in: antidepressant use, (P =.023); hospitalization, (P =.001); outpatient visit, (P =.002); and total health care/drugs, (P =.001).

Conclusions: Elderly MDD patients initiated on escitalopram vs. citalopram had better treatment compliance and lower probability of hospital admissions or restarting depression treatment. Escitalopram patients also used fewer inpatient days and had lower health care costs on average.

REFERENCES:

1. Moore N. Prospective, multicenter, randomized, double-blind study of the efficacy of escitalopram-versus citalopram in outpatient treatment of major depressive disorder. Int Clin Psychopharmacol 2005;20:131–137.
2. Wade AG. A probabilistic cost-effectiveness analysis of escitalopram, generic citalopram and venlafaxine as a first-line treatment of major depressive disorder in the UK. Curr Med Res Opin 2005;21: 631–632.

Poster 173 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

RACIAL DISPARITIES IN THE UTILIZATION OF PERINATEL ADDICTION SERVICES

Catherine R. Friedman, M.D., *Resident, Department of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*; Antoine B. Douaihy, M.D.

SUMMARY:

Pittsburgh demonstrates racial disparities in prenatal health care similar to the rest of the USA. 19% of adult African-American mothers in Pittsburgh do not have first trimester prenatal care, as compared with 5.7% of whites (1). The Perinatal Addiction Center (PAC) treats women in all stages of recovery during and after pregnancy. Almost all PAC patients are on methadone maintenance. By self-report, from 1997–2002 there was little racial difference in the use of opioids in pregnancy in Pittsburgh: 0.4% of white mothers vs. 0.5% of non-white mothers (1). The current study examining PAC

demographics over 18 months from 11/2005–4/2007 demonstrated a large racial disparity in treatment. Only one of 106 women was African-American. To determine if this racial disparity was isolated to perinatal addiction services we compared PAC with an associated methadone maintenance treatment program (MMTP). 25% of those enrolled were African-American and 40% were female. 5% of females in the MMTP were African-American. Together these data suggest that a racial disparity in female enrollment in opioid maintenance treatment increases during the perinatal period. This study is the first stage of a project to examine social, economic, and cultural factors that may cause racial disparities in the use of perinatal addiction services.

REFERENCES:

1. Maternal and Child Health Needs Assessment. (2004) Allegheny County Health Department. Accessed 6/1/2007 at : http://www.achd.net/childhth/pubs/pdf/MCHassessment2004.pdf http://www.achd.net/childhth/pubs/pdf/MCHassessment2004.pdf.
2. Allegheny County Drug and Alcohol Treatment Plan. Allegheny County Department of Human Services, Office of Behavioral Health. Accessed 1/15/2007 at: http://www.county.allegheny.pa.us/dhs/BH/bh.html.

Poster 174 **Saturday, October 13 3:00 p.m.-4:30 p.m.**

FREQUENT USERS OF ACUTE PSYCHIATRIC CARE IN SOUTH CAROLINA EMERGENCY DEPARTMENTS: ANALYSIS BY COST AND DIAGNOSIS

Shilpa Srinivasan, M.D., *Assistant Professor of Clinical Psychiatry and Assistant Director, Geriatric Psychiatry Fellowship Program, Department of Neuropsychiatry and Behavior Sciences, University of South Carolina, 3555 Harden Street, Ext. 15, Medical Park, Suite 301, Columbia, SC 29203*; Butterfly Rudd, M.D.; Meera Narasimhan, M.D.; John Magill,M.S.W.; Richard Harding, M.D.; Ronald Prier, M.D.

SUMMARY:

Objective: To compare characteristics of high users of emergency services and inpatient hospitalizations within South Carolina's Department of Mental Health (DMH) vs. non-DMH users, by payer source and diagnosis.

Methods: High users of South Carolina (SC) psychiatric emergency services were identified as adults with two or more ER visits and/or inpatient hospitalizations for primary behavioral health diagnoses (by ICD-9 codes) from 2003–2004. Data was obtained from the SC State Budget Control Board. Comparisons were made to ensure unduplicated counts. Specialty hospitals were excluded.

Results: Health services utilization by diagnosis:

1.) Among DMH clients, 40% of financial charges were for psychotic disorders and 33% for mood disorders. For non-DMH clients, mood disorders contributed to 32% of financial charges, followed by alcohol and drug dependence at 28%;

2.) Health services utilization by payer source; and 3.) DMH clients comprised 57% of all adult frequent users of acute psychiatric visits (totaling $82,143,978) with the majority covered by Medicare and Medicaid; compared to non-DMH clients (43% at $62,615,804) who were covered mainly by Medicare and private insurance.

Direct cost (inpatients): 1.) Large differences in inpatient lengths of stay were found by diagnosis and payer source; 2.) Indigent/ Self-pay users had lower lengths of stay across all diagnoses among DMH (6.6 days) and non-DMH (5.3 days) users. ER lengths of stay were not influenced; and 3.) Among those insured by Medicaid and Medicare, lengths of stay were highest for mood and psychotic disorders (9.2 and 10.6 vs. 12.1 and 10.5 days respectively).

Conclusions: Results from this study are very reflective of national trends. It emphasizes higher recidivism rates for indigent/self-pay users, due to shorter lengths of hospitalization. Further research is necessary to analyze whether intensive case-management services may impact hospital course length and potentially decrease recidivism rates.

REFERENCES:

1. Hazlett SB et.al. Epidemiology of Adult Psychiatric Visits to US Emergency Departments. Acad Emerg Med. 2004 Feb;11(2):193–195.
2. Fuda KK, Immekus R. Frequent Users of Massachusetts Emergency Departments: A Statewide Analysis. Ann Emerg Med. 2006 Jul;48(1):9–37.

Symposium 1 **Thursday, October 11**
8:30 a.m.-11:30 a.m.

RECOVERY IN A COMMUNITY SETTING: THE PHILADELPHIA MODEL

Edward A. Volkman, M.D., *Clinical Professor of Psychiatry, Drexel University, 27 E. Mt. Airy Avenue, Philadelphia, PA 19119*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the import of the transformation to a recovery model from several perspectives, including the consumers, advocacy groups, county government, state hospital physicians, and a large community mental health center.

OVERALL SUMMARY:

The format of the symposium will be to present papers describing the opportunities, impediments, and implementation plans for transforming the current medical model of treatment of the Severely Mentally Ill (SMI) into a Recovery/Resiliency model from the perspective of each of the stakeholders in the process. These perspectives will include the consumer of services and their advocates, the state hospital psychiatrist, the local government concerned with overseeing this transformation, and a large Community Mental Health Center (CMHC) responsible for nearly seven thousand consumer lives. The consumers and their advocacy group will be folded into a presentation from the Mental Health Association of Southeastern Pennsylvania. Dr. Diamond, the Medical Director of Pennsylvania's OMHSAS, will discuss the role of the state hospital psychiatrist. The local government's perspective will be presented by Dr. Margaret A. Minehart, the Medical Director of the Philadelphia Office of Behavioral Health. Dr. Paul Sachs, Executive Director of NHS Human Services of Philadelphia, will give the CMHC perspectives. The presenters will focus on efforts to forge a collaborative approach to implementing the transformation of the model. They will aim to describe how their various interests can synergize the overall effort, and to avoid possible competitive roadblocks to successful implementation.

No. 1A
RECOVERY TRANSFORMATION IN A COMMUNITY MENTAL HEALTH AGENCY

Paul Sachs, Ph.D., M.B.A., *Executive Director, NHS Human Services, 27 E. Mt. Airy Avenue, Philadelphia, PA 19119*

SUMMARY:

Recovery transformation in mental health treatment has focused, understandably, on the delivery of services to mental health consumers and the opportunities provided to these consumers. Although this focus is clearly essential, it may obscure other fundamental operations which an agency must manage in attempting such a transformation. The present paper examines the recovery transformation process for a large urban community mental health agency. The agency's horizontal and vertical organization presents a complex challenge to such a transformation. The methods of meeting this challenge are presented. Methods of incorporating feedback from consumer, staff and community stakeholders are presented. The impact of the transformation on personnel and facility management are discussed. A checklist of key criteria for a transformation is provided to participants.

No. 1B
TRANSFORMATION TO RECOVERY: GOVERNMENT ROLE

Margaret A. Minehart, M.D., *Medical Director, Philadelphia Department of Behavioral Health, 1101 Market Street, 7th Floor, Philadelphia, PA 19107-5830*

SUMMARY:

This paper will describe the role of the Philadelphia Department of Behavioral Health in shaping the delivery system of services for the consumers of mental health and addiction services. The dimensions of this role include funding allocation decisions, oversight of the quality of the clinical care afforded consumers, setting standards for providers, initiating requests for program innovation, and superintending outcome studies to demonstrate the efficacy of programs. One of our prominent initiatives involves the transformation of the partial hospital programs at the various CMHC's in Philadelphia. We are currently considering the submissions of a number of those agencies. All are aimed at transforming these programs from mere stabilizing and medicating models of patient care to a recovery focused set of alternatives. These alternatives aim to make use of a much greater variety of services which will be aimed at the specific needs of a variegated group of consumers which will be ascertained by close collaboration with consumer advocacy groups and with groups of consumers themselves. Our aim is to empower the consumers by having our programs actively solicit their input on their needs as they define them rather than rely on a "we know what's best for them" model.

No. 1C
STATE HOSPITAL PSYCHIATRISTS AND THE RECOVERY MODEL: OPPORTUNITIES AND IMPEDIMENTS

Mary E. Diamond, D.O., *Medical Director, OMHSAS, P.O. Box 2675, Harrisburg, PA 17105*

SUMMARY:

State hospitals, with their vastly reduced populations and vastly reduced numbers, now house the most seriously, chronically ill patients. Their function has historically moved from places of confinement in the early to mid-nineteenth century to self-contained communities in the late nineteenth century to the medical model which has characterized them for most of the twentieth century. The revolution in the treatment of schizophrenia has long removed drug responsive patients from their environs. The patients who still inhabit the system are the so-called "irreducible minimal state hospital populations." The operation of these facilities has passed out the control of psychiatrists, and into the hands of administrators. However, in the daily function of these institutions care has remained traditionally medical model, and the psychiatrists who staff them have operated in fealty to that model. The task now is to enlist these psychiatrists in the effort to help even these most chronically and refractory patients in a program of empowerment to enhance their lives as much as possible within the constraints of their illness. This also involves the administration of these facilities in creating an atmosphere where both the model and the psychiatrists can be transformed into a recovery oriented system.

No. 1D
CONSUMERS AS ACTIVE PARTNERS IN THE PUBLIC MENTAL HEALTH SERVICE DELIVERY SYSTEM

Jeanie Whitecraft, M.Ed., *Mental Health Association of Southeastern Pennsylvania, 536 Heacock Road, Yardley, PA 19067*; John Farmer, M.Ed.; Betsy Kidwell, B.A.

SUMMARY:

Representatives from the Institute for Recovery and Community Integration of the Mental Health Association of Southeastern Pennsylvania will address several areas of the recovery paradigm shift in the service delivery system. The National Consumer Psychiatric Survivor Self – Help Recovery Movement will be chronicled from the 1940's through to the present, which includes the development of the Wellness Recovery Action Plan (WRAP). Specific topics will include the history and implementation of recovery in the Commonwealth of Pennsylvania, which include diversity initiatives and the Certified Peer Specialist Program. The Certified Peer Specialist Training around the nation will also be chronicled. Management and supervision in a recovery oriented environment will also be presented.

REFERENCES:

1. The Recovery Model and Seclusion and Restraint, McLoughlin, Kris A; Getter, Jeffrey L., SourcePsychiatric Services. Vol 57(7) Jul 2006, 1045.
2. Will hospitals recover? Smith, Russell C.; Bartholomew, Thomas; American Journal of Psychiatric Rehabilitation. Vol. 9(2), May–August 2006, 85–100.
3. Engaging patients and family members in patient safety—the experience of the New York City Health and Hospitals Corporation, Wale JB. Moon RR., Psychatric Quarterly. 76(1):85–95, 2005.
4. Hospitals Recover?: The Implications of a Recovery-Orientation. Smith, Russell C; Bartholomew, Thomas; Journal of Psychiatric Rehabilitation. Vol 9(2) May–Aug 2006, 85–100.

Symposium 2 **Thursday, October 11 2:00 p.m.-5:00 p.m.**

UNDERSTANDING DIVERSITY IN THE GULF COAST: PROVIDING CULTURALLY COMPETENT, CONSUMER-CENTERED, RECOVERY-ORIENTED CARE ACROSS THE AGE SPECTRUM

OMNA on Tour in the Gulf Coast Track

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Laila F.M. Contractor, M.D., *Resident, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15217*; Hendry Ton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the spectrum of mental health related beliefs and practices of the predominant cultural groups in Louisiana and the Gulf Coast.

OVERALL SUMMARY:

The Surgeon General's Report on Mental Health, Supplement on Culture, Race and Ethnicity advises that culture counts in mental health services and one size does not fit all. This symposium will attempt to characterize four of the prominent racial, ethnic and cultural groups in the Gulf Coast region in terms of their experiences, as well as their mental health and coping responses in the face of the disaster and displacement. By

understanding the cultural flavor of these populations, mental health practitioners will be better able to provide humane, recovery-oriented, consumer-centered services.

No. 2A
MENTAL HEALTH OF PEOPLE OF AFRICAN DESCENT

Roger L. Wortham, M.D., *Medical Director, North Baltimore Center, 2225 North Charles Street, Baltimore, MD 21218*

SUMMARY:

People of African descent, previously the predominant racial group in New Orleans, were particularly hard hit by Hurricane Katrina, the breaching of the levees and the resulting cataclysmic floods. This presentation will focus on the impact of the flood on the mental health of black New Orleanians. African American world views and specific cultural beliefs and practices were evident in their effort to cope with the disaster and its aftermath. However, it is important to distinguish between the manifestations of truly cultural expressions versrs. those related to low socioeconomic status and a history of living in an environment of poverty. This differentiation is important so as not to confuse normal responses to social deprivation with psychiatric symptoms and diagnoses which can lead to unnecessary and inappropriate treatment. Furthermore, there is a need to identify and use as a resource, those cultural practices and beliefs among African Americans that help to sustain them, foster community resilience, and rebuild social fabric.

No. 2B
MENTAL HEALTH OF PEOPLE OF AMERICAN INDIAN DESCENT

Frank Canizales, M.S.W., *Social Worker, 3109 Verona Court, Silver Spring, MD 20906*

SUMMARY:

In considering the mental health of people from Indian country in the context of the Gulf Coast disasters or any U.S. disaster, one must consider the recurrent theme of trauma in American Indian life. People of American Indian descent have withstood ongoing trauma of significant magnitude in the various territories of the U.S. including the Gulf Coast. Despite their experience of historical trauma and oppression, Native people have survived by refusing to assimilate and holding fast to their cultural beliefs and practices. The presenter will explain, in detail, how American Indian people cope with acute and chronic trauma in an effort to maintain equilibrium and mental wellness.

No. 2C
MENTAL HEALTH OF PEOPLE OF CAJUN DESCENT

Oscar J. Bienvenu Jr., M.D., *907 Harling Lane, Natchitoches, LA 71457*

SUMMARY:

This presentation will focus on the Cajun people of Louisiana, descendants of people who originally migrated from the Arcadian part of Canada to Louisiana in the 18th century. The presenter, a man born and raised in Opelousas, LA, worked as a cardiologist in New Orleans for many years. He ultimately received psychiatric training and worked in a public psychiatry clinic in rural Louisiana where he provided mental health care to Cajun people. Using the format of the cultural formulation, he will describe how the identity, world view, and family relationships informs their experience of mental health and mental illness.

No. 2D
MENTAL HEALTH OF PEOPLE OF ASIAN DESCENT

Juliet Choi, Esq., *Senior Associate, National Partnership Development, American Red Cross, 2025 E. Street, N.W., Washington, DC 20006*

SUMMARY:

Many people of Asian descent who reside in the Gulf Coast region hit by Hurricane Katrina are or were formerly shrimpers and fisherman. Many of these Asian Americans have a common experience of dealing with the pressures of immigration and refugee status and the obstacles created by language barriers and limited English proficiency. The displacement of Gulf Coast citizens wrought by Katrina, has worsened an already difficult situation for Asian Americans. The lack of and cultural and linguistic outreach has had a major impact on access to general health and mental health care for this vulnerable population. This presentation will focus on the mental health needs of people of Asian descent in the context of the Gulf Coast disaster. The presenter will offer strategies to bridge linguistic and cultural gaps in service through establishment of formal partnerships with local and national ethnic minority organizations.

No. 2E
MENTAL HEALTH OF PEOPLE OF LATINO/A DESCENT

Andres J. Pumariega, M.D., *Chair, Department of Psychiatry, The Reading Hospital and Medical Center, Sixth Avenue and Spruce Street, Reading, PA 19611*

SUMMARY:

Latinos/ Hispanics are the largest ethnic minority pop-population in the United States, numbering over 30 million and over 14 percent of the U.S. population. Though there is recognition of this growing population and its impact on educational and social services resources, there is little recognition of the special challenges and needs they face developmentally and emotionally. Latinos are affected by socioeconomic forces and pressure to acculturate, with resulting major increases in their mental health morbidity. This is exemplified by the findings from the most recent CDC Youth Health Risk Survey, which shows Latino youth being at highest risk for suicidal ideation and completed suicides of all racial/ ethnic groups in the United States. Latinos already face significant stressors and resulting trauma as part of their immigration process, but the recent experiences with Hurricane Katrina have served to point out their greater vulnerability to added traumas. This presentation will review the many mental health challenges faced by Latinos in the United States, the impact of acculturation and marginalization on rising mental health morbidity, and developing approaches that are demonstrating some evidence-base to address the special needs of the Latino population in the United States, and especially in the wake of major disasters.

REFERENCES:

1. U.S. Department of Health and Human Services. A Report of the Surgeon General. Mental Health: Supplement on Culture, Race and Ethnicity. 2001.
2. Lim, R: Clinical Manual of Cultural Psychiatry. Arlington, VA: American Psychiatric Publishing, Inc. 2006.
3. Fleming CM: American Indian and Alaska Native Patients in, Ed. Lim, R: Clinical Manual of Cultural Psychiatry. Arlington, VA: American Psychiatric Publishing, Inc. 2006, pp.175–203.
4. Trimble JE, Thurman PJ: Ethnocultural considerations and strategies for providing counseling services to Native American Indians in Counseling Across Cultures, 5th Edition.
5. Lim R, Ton, H: The Assessment of Culturally Diverse Individuals in, Ed. Lim, R: Clinical Manual of Cultural Psychiatry. Arlington, VA: American Psychiatric Publishing, Inc. 2006, pp. 3–28.
6. Mental Health of People of Asian Descent (especially Vietnamese): Juliette K. Choi, Esq.
7. Choi, JK: Current challenges faced by Asian Americans and Hurricane Katrina: Highlights on Language Services and Physical and Mental Health Concerns. Asian American Justice Center. Advancing Equality. 2005. www.advancingequality.org.
8. Four Racial Ethnic Panels (Pumariega, A.J.: Chair, Latino Panel) Cultural Competence Standards for Managed Mental health Services for Four Under served/ Underrepresented Racial/Ethnic Groups. Rockville, Md.: Center for Mental Health Services, Substance Abuse and Mental Health Administration, U.S. Department of Health and Human Services, 1999.
9. Pumariega, A.J., Rothe, E., & Pumariega, J.B. Mental Health of Immigrants and Refugees. Community Mental Health Journal. 41(5):581–597, 2005.

Symposium 3 **Thursday, October 11 2:00 p.m.-5:00 p.m.**

FACILITATING RESILIENCE AND RECOVERY BEFORE AND AFTER TRAUMA

Robert H. Abramovitz, M.D., *Chief Psychiatrist, Center for Trauma Program Innovation, Jewish Board of Family and Children's Services; 120 West 57th Street, New York, NY 10019*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Explore empirical research and theoretical models of resilience; 2.) Identify the expanded conceptual basis for resilience and approaches to its study; and 3.) Apply a variety of new approaches designed to promote and enhance resilience or mitigate the impact of events on an individual adaptive capacity.

OVERALL SUMMARY:

New Orleans is a prime example of community and academia working together to learn while recovering. We know that community recovery involves restoring and rebuilding psychological, social and physical infrastructures. Attention to psychological and social recovery has lead to a new focus in the trauma field – understanding resilience. Resilience is now seen as an adaptive capacity that can be promoted, enhanced or maintained by use of a variety of interventions, rather than an intrinsic character trait. Resilience refers to the ability to cope with stress and adversity. A focus on resilience shifts the emphasis from psychopathology to a focus on factors that promote recovery. This symposium will have four presentations: a conceptual overview and approaches to the study of resilience; a developing model for enhancement of resilience prior to trauma exposure; the use of a new Psychological First Aid manual in the aftermath of Hurricane Katrina collaboratively developed by the National Center for PTSD and the National Child Traumatic Stress Network and SAMHSA designed to mitigate the impact of traumatic exposure; and descriptions of an intervention program working with First Responders that were highly exposed to Hurricane Katrina.

No. 3A
CAN WE PREPARE INDIVIDUALS FOR WORK-RELATED TRAUMA EXPOSURE?

Josef Ruzek, Ph.D., *Associate Professor of Psychology, Pacific Graduate School of Psychology, 935 East Meadow Drive, Palo Alto, CA 94025*; Christopher Layne; Richard F. Mollica, M.D.

SUMMARY:

Cognitive-behavioral treatments have been extensively used to treat symptoms and problems after exposure to trauma. It is likely, however, that cognitive-behavioral preventive interventions can also be developed for delivery prior to trauma exposure for individuals employed in occupations associated with a high likelihood of exposure to work-related trauma. In this presentation, we explore methods of preparing employees for trauma, derived from psychological models of traumatic stress response and PTSD. Key cognitive and behavioral processes affecting adaptation to traumatic events will be identified, and their preventive implications explored. Concrete practical interventions targeted at reducing intensity of emotional and physiological exposure during potentially traumatic events, preventing development and activation of negative trauma-related appraisals, and enhancing post-trauma coping, will be suggested.

No. 3B
KEEP IT REAL: GROUP WORK TO ENHANCE RESILIENCY

Paula G. Panzer, M.D., *Deputy Chief Psychiatrist, and Associate Director, Center for Trauma Program Innovation, Jewish Board of Family and Children's Services; and Former Chair, APA/IPS Scientific Program Comimitte, 120 West 57th Street, New York, NY 10019*; Anne Jacobs; Cardoza Lopez

SUMMARY:

Strengthening an individual's capacity to cope with subjective reactions of fear, helplessness, confusion, and maladaptive beliefs resulting from threat may enhance resiliency and contribute to preventing PTSD. We will present Keep it REAL, a group training program to help adults prepare for and cope with stress and threats. Keep it REAL helps adults meet the challenges of living in an uncertain world where disasters and other threats occur. The Keep It REAL group helps participants build a sense of safety and active coping while experiencing anxiety over threats and chronic uncertainty. Critical components of the curriculum are captured in the acronym REAL: Risk Assessment (obtaining reliable information and reviewing relative threat risk), Emotional Knowledge (understanding the biology of the fear response and its effects on thinking and functioning), Active Coping (strategies for living with fear and uncertainty), and Life Safety Plan (developing personal, family, and professional strategies for relative safety). Use of this group for at risk populations will be discussed.

No. 3C
PSYCHOLOGICAL FIRST AID

Melissa Brymer, Ph.D., Psy.D., *Director, Terrorism and Disaster Programs, Department of Psychology, UCLA, 11150 West Olympic Boulevard, Suite 650, Los Angeles, CA 90064*; Robert S. Pynoos, M.D.; Howard J. Osofsky, M.D., Ph.D.

SUMMARY:

This presentation will offer an overview of Psychological First Aid, a modularized system of interventions intended for use in the acute aftermath of disasters and mass violence. The Second Edition Psychological First Aid Field Operations Guide was recently developed by the National Child Traumatic Stress Network and the National Center for PTSD. It includes clear, practical interventions across the developmental lifespan, as well as educational handouts for both practitioners and survivors. Psychological First Aid is designed to reduce the initial distress caused by disasters and mass trauma, and to foster short- and long-term adaptive functioning. Principles and techniques of Psychological First Aid meet four basic standards: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) utilizes interventions geared to developmental age; and (4) culturally informed. Video vignettes of core skills will be shown to highlight some of the core components of Psychological First Aid.

No. 3D
WORKING WITH FIRST RESPONDERS IN THE AFTERMATH OF HURRICANE KATRINA

Howard J. Osofsky, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Louisiana State University Health Sciences Center, 2020 Gravier Street, New Orleans, LA 70112-2865*; Joy Osofsky, Ph.D.; Alan L. Steinberg, M.D.; B. Rafael

SUMMARY:

Hurricane Katrina highlighted the crucial role of first responders in times of disaster, as well as stress on them and their families. They were required to meet the

challenges to community, maintaining safety, rescuing and saving lives, and helping to evacuate those with special needs. They dealt with disruptions in communication, lack of availability of equipment, problems with evacuation, increased work related medical risk, and painful triage decisions. First responders currently have additional personal pressures associated with economic losses, slowness of recovery, and separation from families. Perceived self efficacy, individual characteristics, organizational preparation and structure, loyalty to colleagues and work, social support, a sense of meaning and hope, and spirituality are among the protective factors that aid their response and resilience. About 10% reported symptoms of PTSD and nearly a quarter reported symptoms of depression. Marital problems are more prevalent. The authors will discuss immediate response and ongoing interventions with first responders and their families.

REFERENCES:

1. The concept of resilience revisited Siambabala Bernard Manyena Disasters; Volume 30, Issue 4, Page 434 - December 2006 doi:10.1111/j.0361-3666.2006.00331.x Volume 30, Issue 4.
2. Resilience in the Face of Potential Trauma George A. Bonanno Current Directions in Psychological Science; Vol. 14, Issue 3, Page 135; June 2005.
3. LeDoux, J.E. & Gorman, J.M. (2001). A Call to action: Overcoming anxiety through active coping (editorial). American Journal of Psychiatry, 188, 1953–1955.
4. National Child Traumatic Stress Network and National Center for PTSD, Psychological First Aid: Field Operations Guide, 2nd Edition, July 2006.
5. Osofsky, H. (in press) In the Eye of Katrina: Surviving the Storm and Rebuilding an Academic Department of Psychiatry, Academic Psychiatry, 2006.

Symposium 4 **Thursday, October 11**
2:00 p.m.-5:00 p.m.

WHAT YOUTH WANT FROM A PSYCHIATRIST: A YOUTH PERSPECTIVE ON PSYCHIATRIC SERVICES

Charles W. Huffine, Jr., M.D., *Private Practice, Adolescent Psychiatry; Medical Director, Children and Adolescent Programs, and Medical Director, King County Mental Health Services; and Former Chair, APA/IPS Scientific Program, 3123 Fairview Avenue, East, Seattle, WA 98102*; Lisa M. Cullins, M.D., *EMQ Children and Family Services, 251 Llewellyn Avenue, Campbell, CA 95008*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Define the emerging youth movement in child and adolescent mental health; 2.) Recognize how it relates to the larger system of care, and its relationship with the family advocacy movement for children and youth; 3.) Identify the key factor of collaboration with professionals, especially psychiatrists; and 4.) State how the youth movement is related to adult consumerism and broader human rights issues.

OVERALL SUMMARY:

In the evolution of the recovery movement the driving force has been consumers. Articulate consumers spoke out initially due to their dissatisfaction with the systems of care for individuals with serious and persistent mental illness. In a parallel development in the evolving efforts to create a values based system of care for children and youth with serious emotional disturbances, (SED) consumer families organized in many communities and nationally under the banner of the Federation of Families for Children's Mental Health (FFCMH.) Through a major grant program of SAMHSA, which seeks to promote System of Care reforms for SED children and youth, a youth consumer movement began to appear. Within the last five years, in affiliation with the FFCMH and the SAMHSA grants, a youth movement has emerged which is beginning to articulate a distinct consumer perspective on services to children and youth. This ''youth voice'' will be brought to this symposium. Three youth leaders, representing diverse backgrounds and experiences, will give their stories with emphasis on the quality and impact of services they received, what worked for them to allow them to emerge as youth leaders, and what they see as roles for psychiatrists in promoting recovery in children and youth. This group of youth will speak to problematic experiences, with mental health systems, including psychiatric services, and they will share strikingly positive experiences with psychiatrists as well. Together they will discuss a national movement, Youth M.O.V.E., which is striving to create a handbook for how psychiatrists can best serve youth.

No. 4A
HEALTH AND ACTION AS PART OF THE SYSTEM OF CARE

Charles W. Huffine, Jr., M.D., *Private Practice, Adolescent Psychiatry; Medical Director, Children and Adolescent Programs, and Medical Director, King County Mental Health Services; and Former Chair, APA/IPS Scientific Program, 3123 Fairview Avenue, East, Seattle, WA 98102*

SUMMARY:

Dr. Huffine led efforts to create an organization, Health 'n' Action as part of the System of Care SAMHSA grant received by King County. in Washington State. He will briefly describe the growth of this organization and the leadership of youth and their adult youth coordinators in influencing SAMHSA to make youth consumerism a core part of the grant program.

No. 4B
SOCIAL SERVICES FOR FOSTER CARE YOUTH

Lisa M. Cullins, M.D., *Assistant Training Director, Department of Psychiatry, Children's National Medical Center, 111 Michigan Avenue N.W., Washington, DC 20009*

SUMMARY:

Dr. Cullin will draw from her unique experience as a nearly full time psychiatrist for the social services program for children and youth in Washington, DC, and her perception of the need for foster youth to organize to address both their care by a social services system, but also services they have needed from mental health, substance abuse and juvenile justice sub-systems.

No. 4C
ADDRESSING THE CYCLES OF POVERTY

Myrna Carpenter, M.D., *Youth Involvement Coordinator, St. Cloud, Minnesota STARS for Children's Mental Health, 407 Washington Street, Monticello, MN 55462*; Laila F.M. Contractor, M.D.

SUMMARY:

Dr. Carpenter will describe her evolving attitudes as a psychiatric provider in training to the cycles of poverty, child abuse, and foster care and possible points of intervention in organizing young mother's to demand more relevant services.

No. 4D
YOUTH: THEIR VOICES WILL BE HEARD

Lorrin Gehring, *Youth Resource Specialist, The Federation of Families for Children's Mental Health, 1460 West 1700, North, Provo, UT 84604*; Marvin Alexander

SUMMARY:

The youth will participate in the presentations. As a group, they will tell their stories and how they evolved into leadership roles in articulating youth voice. They will describe their efforts in local and national youth organizations and the role of partnering with professionals in the development of a youth consumer movement.

REFERENCES:

1. Huffine, C.W., Anderson, D. (2003). Family Advocacy Development in Systems of Care. In A.J. Pumariega, N.C.Winters (Eds.), The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry (pp. 35–65). San Fransisco, CA: Jossey-Bass.
2. Youth Group Development: a Website of the Technical Assistance Partnership http://www.tapartnership.org/youth/default.asp.
3. Federation of Families for children's mental health. http://www.ffcmh.org.
4. Voices in action. http://www.voices-action.org.

Symposium 5 **Thursday, October 11 2:00 p.m.-5:00 p.m.**

MOVING FROM COERCION TO ENGAGEMENT: GOING DUTCH

Rene C.A. De Veen, M.D., *Psychiatrist, Mediant, Saffierstraat 15, Boekelo 7548CC, Netherlands*; Margaret Bennington-Davis, M.D., M.Ed., *Executive Vice President of Medical Services, Cascadia Behavorial Health Care, 23420 S.W. 65th Avenue, Tualatin, OR 97062-9714*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the Dutch initiative of implementing a non-restraint and non-seclusion program, based on and compared to similar U.S. initiatives.

OVERALL SUMMARY:

Background: In the Netherlands seclusion is a widespread intervention. The presented initiative aims at reducing seclusion by way of achieving a change in treatment culture using alternative means of intervention instead of seclusion. The use of Comfort Rooms is combined with the Engagement Model, to create a safer treatment milieu. In this model, an open, trauma-informed and hospitable attitude of employees is crucial. The model is implemented in three years. The current study assesses factors that influence the process of this planned culture change and the effect of the introduction of this American intervention in a Dutch hospital.

Objective: Is this change of treatment culture in Holland possible? Does the concept of comfort rooms combined with the Engagement model provide a feasible way of working and does it reduce seclusion incidents?

Method: By means of concept mapping interviews with advocates of 'Sanctuary movement', Comfort

Room and Engagement Model initiatives in the U.S., we realized a scientific translation of the concept. With regular intervals the same interview will be done with stakeholders in the Dutch setting. Data on seclusion and other interventions following incidents were sampled as a means to chart change.

Results: Results of the concept mapping interviews will be presented. Differences between Dutch and American practices and treatment culture will be highlighted. Outcome measures will be presented.

No. 5A
OVERVIEW OF RESULTS OF THE COMFORT ROOM PROJECT RESEARCH COMPARED WITH RESEARCH INTO DETERMINANTS OF SECLUSION ELSEWHERE IN THE NETHERLANDS

Eric Noorthoorn, M.D., Ph.D., *Associate Professor, Mediant, Saffierstraat 15, Boekelo 7548CC, Netherlands*; Wim Janssen, Ph.D.; Margaret Bennington-Davis, M.D., M.Ed.; T. Abma, M.D.; A.N. Khadavi, M.D.

SUMMARY:

Background: Decision making processes regarding seclusion are complex. One factor is the level of training of staff involved in seclusion incidents. Research in the Netherlands has shown that this is of great importance and should be assessed, to learn more about how these decisions come about. Earlier research indicates that if two equally well trained registered nurses or two less trained nurses assess the decision for a seclusion, this intervention is mores often chosen, compared to the situation in which a well trained nurse together with a less trained nurse assess the need for seclusion. This finding could have far stretching implications for planning of staff-attendance on wards.

Objectives: As staff training level is one of the determinants of the use of restraint and seclusion, data collection on this matter is an important feature in the Comfort Room Project of Mediant. Research on other variables will be also included in the study (as described in other papers).

Results: An overview and first results will be given of all relevant instruments for assessing and describing the factors that could affect the change in treatment culture that we aim at.

No. 5B
ELEMENTS OF THE COMFORT ROOM PROJECT MEDIANT: A TRANSLATION OF U.S. NON-SECLUSION INITIATIVES FOR THE DUTCH SITUATION

Rene C.A. De Veen, M.D., *Psychiatrist, Mediant, Saffierstraat 15, Boekelo 7548CC, Netherlands*; T. Hoekstra, M.D.; Eric Noorthoorn, M.D., Ph.D.; Tim Murphy, M.S.; Guy Widdershoven, Ph.D.

SUMMARY:

Dr. DeVeen will address the elements of the Comfort Room Project Mediant and how the U.S. non-seclusion initiatives will affect Dutch hospitals. He will focus on whether or not these Comfort Rooms combined with the Engagement Model provide a feasible way of working and does it reduce seclusion incidents.

No. 5C
FIRST RESULTS OF INTRODUCING THE COMFORT ROOM MEDIANT AND THE CHANGE IN ATTITUDE IN NURSING STAFF

Hans Poelert, *Chief Burse, Co-Project Leader, Comfort Room Project, Mediant, Broekheurnering 1050, Enschede, Netherlands 7546*; R.C. Patel, M.D.; Bert Lendemeijer, Ph.D.

SUMMARY:

The process of change in treatment culture regarding restraint and seclusion in the psychiatric hospitals Helmerzijde and De Opmaat (part of Mediant Geestelijke Gezondheidszorg), as a result of the introduction and implementation of the Comfort Room Project Mediant will be described. The role of management, medical staff and nursing staff, as well as supporting services in this process will be analyzed. Data from the study on this process will be translated in charts and papers that will be used to enhance the process of change. Comparisons with other initiatives in the Netherlands that aim at reducing restraint and seclusion will be made. Concept mapping interviews as an instrument will be used to clarify determinants that are important for the culture shift we aim at. Positive as well as negative factors in this process will be mentioned, to guide decision makers and management in the U.S., as well in the Netherlands.

No. 5D
DETERMINANTS OF RESTRAINT AND SECLUSION: A SCIENTIFIC ANALYSIS

Fleur Vruwink, M.D., *Resident in Psychiatry, Mediant, Broekheurnering 1050, Enschede, Netherlands 7546*; Bert Lendemeijer, Ph.D.

SUMMARY:

Background: In this presentation the incidence of aggression incidents will be discussed and related to the departments with and without Comfort Rooms within two mental hospitals, using the data of the first year of

assessment. A total of 15 departments of the two hospitals participated in the study.

Objective: The incidence of the aggression incidents will be related to outcomes as measured in various intervention strategies, such as the use of Comfort Rooms, holding and restraint techniques, intensive care, and the use of seclusion. The influence of confounder and effect modification variables, such as substance abuse and severity of the psychiatric disorder will be assessed.

Method: Various validated instruments (HCR-20, SOAS-r, Kennedy Axis-V) were used on all departments to collect data on seclusion incidents.

Results: The first data collected with these instruments will be presented and first results will be presented.

No. 5E
CONSUMER COMMENTS ON THE COMFORT ROOM PROJECT MEDIANT: FIRST IMPRESSIONS AND COMMENTS

Yvonne Hekkink, *Consumer Representative, Mediant, Broekheurnering 1050, Enschede, Netherlands 7546*; A.R. Atkinson, M.D.; M.G.M. Janseen

SUMMARY:

Background: In this presentation the consumer perspective on seculsion is presented. The presenter is a consumer who has personally experienced seclusion. She will give an account of her feelings and experiences. She is also a consumer representative who participates in several comsumer initiatives in the Netherlands and will relate to the broader perspective of restraint and seclusion.

Objective: The Mediant delegation that presents this symposium feels that it is pivotal that health care representatives are confronted with the possible detrementous effects of seclusion for patients.

Method: The consumer presentation will not be an academic appraisal of this matter. The presenter will, as a member of the Comfort Room Mediant Project Group, describe, from a consumers point of view, the experiences of Mediant-consumers with the new approach.

Results: Positive results, as well as shortcomings of one year of working with the Comfort Room Mediant Project will be highlighted.

REFERENCES:

1. Murphy T, and Bennington-Davis M., Restraint and Seclusion, HcPro, University of MA, Marblehead USA, ISBN 1-57839-662-0, 2005.
2. Restraint and Seclusion, Murphy T. and Bennington-Davis M., HcPro, Marblehead MA, 2005, ISBN 1-57839-622-0.
3. Dwang en Drang in de psychiatrie, Abma T. et.al; Lemma uitgeverij Utrecht, 2005.
4. Association between seclusion and restraint and patient-related violence, Psych. Services 2004, Nov; 55(11):1311–2.
5. Seclusion, the inside story, Journ. of Psych. and mental health Nursing, 11, 276–283, 2004.

Symposium 6 **Friday, October 12 8:30 a.m.-11:30 a.m.**

INTERNATIONAL MENTAL HEALTH AND CONFLICT

2006–2008 APA/Bristol-Myers Squibb Fellows
Marcy J. Forgey, M.D., M.P.H., *2006–2008 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Cambridge Health Alliance, 255 Massachusetts Avenue, Apt. 401, Boston, MA 02115-3511*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Describe the mental health outcomes of conflicts in the 20th/21st centuries; 2.) Recognize the relevance of the field to mental health professionals; 3.) Identify the mental health needs in conflict areas; 4.) Define the issues in developing appropriate interventions; 5.) Evaluate the application of the abovementioned areas in the case of Darfur and understand how mental health professionals may serve as advocates to end the conflict; 6.) List strategies of community reconciliation and healing; and 7.) Identify means in which a mental health professional may operate in a post-war context.

OVERALL SUMMARY:

Mental health is finally being recognized as an essential component of healing and recovery for societies affected by war, genocide, and other violent conflicts. For example, the World Health Organization has called "upon all governments, organizations and institutions to adopt and implement . . . steps, in taking up the challenge to prevent and reduce mental disorders and mental health problems, to restore hope, dignity, mental and social well-being, and normality to the lives of refugees, displaced and other populations affected by conflict." Researchers have documented a high rate of depression, anxiety, and trauma-related symptoms among conflict survivors. However, it is becoming increasingly clear that effective interventions are more complex than the simple treatment of symptoms in individuals. It is unclear which syndromes or disorders should be the focus of attention, what treatment modalities are appropriate in culturally diverse settings, and even to what degree interventions should be targeting individuals vs. communities. The role of mental health providers is

also changing, with some suggestion that it should be broadened beyond short-term relief work to encompass training, program development, capacity building, and advocacy as well. In addition, reconciliation and redress have become essential components of long-term healing at the community level. In this symposium for mental health providers, we will discuss the history of mental health issues in conflicts worldwide and examine the issues and evidence involved in the development of

No. 6A
INTRODUCTION TO MENTAL HEALTH IN CONFLICT SETTINGS

Marcy J. Forgey, M.D., M.P.H., *2006–2008 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Cambridge Health Alliance, 255 Massachusetts Avenue, Apt. 401, Boston, MA 02115-3511*

SUMMARY:

There is increasing awareness that problems in conflict and post-conflict areas are not only physical, but also mental and emotional. Research suggests that psychosocial consequences can be prevalent, persistent, and problematic. For example, studies have shown that survivors of conflict can experience symptoms decades later and that communities which have experienced conflict may be more vulnerable to recurrent cycles of violence. This educational session will serve as a general overview to the field of mental health related to conflict. We will explore the history of this field as we examine mental health aspects of 20th century conflicts including war, genocide, and political torture. We will describe the individual, social, and cultural factors which contribute to psychiatric vulnerability in the conflict setting. Such psychiatric outcomes such as depression, post-traumatic stress disorder, and "cultural bereavement" will be discussed, among others. The impact of conflict on the mental health of children will also be addressed. Finally, we will consider why theses issues would call for the involvement of mental health professionals in healing and recovery from conflict.

No. 6B
MENTAL HEALTH INTERVENTIONS IN CONFLICT: ISSUES, EVIDENCE, AND IMPLICATIONS

Trina E. Chang, M.D., M.P.H., *2006–2008 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Massachusetts General Hospital, WACC 812, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

There is a very high rate of depression, anxiety, and trauma-related symptoms among conflict survivors. This session will address the need for effective interventions that can treat the symptoms in these individuals to restore hope dignity, mental and social well-being, and normality to their lives.

No. 6C
A CASE STUDY OF MENTAL HEALTH NEEDS AND INTERVENTIONS IN AREAS OF CONFLICT: THE CASE OF DARFUR

Ilana R. Nossel, M.D., *2006–2008 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Columbia University, 1051 Riverside Drive, Box 109, New York, NY 10032*

SUMMARY:

This session will examine, in detail, the situation in Darfur from a mental health perspective. Darfur has been described as "the largest and most complex humanitarian problem on the globe," by Antonio Guterres, the United Nations High Commissioner for Refugees. The crisis in Darfur is of tragic proportions, with ongoing bloodshed, starvation, systematic rape, and displacement. The scope of the conflict begs for international attention and intervention. In this session, we will review the data on psychiatric morbidity and mortality in Darfur and among Darfurian refugees in neighboring areas. Using the concepts and models introduced in the symposium as a backdrop, we will examine the services being provided, looking at the structure, theoretical framework, and funding of these interventions. We will explore the challenges to providing mental health care in this setting and will identify which are the most critical unmet needs. With input from participants, we will look at strategies for enhancing the services being provided. We will explore the role American psychiatrists can play in serving as advisors in the development and implementation of mental health interventions and as advocates to help end the conflict.

No. 6D
COMMUNITY HEALING AND RECONCILIATION

Sonali Sharma, M.D., M.S., *2006–2008 APA/Bristol-Myers Squibb Fellow; and Resident, Department of Psychiatry, Cornell University, 210 Lafayette Street, Apt. 5C, New York, NY 10012-4041*

SUMMARY:

Periods of mass violence and conflict often confer substantial vulnerability at multiple levels. At an individual level, the disappearances of loved ones, the sequela of torture, or witness to violence are far reaching and have a devastating impact. Families are often torn apart and communities left in physical disarray. The road to recovery is fraught with difficulty and must address both the individual and collective needs within a society. This session will focus on such large scale human rights abuses and various methods of redress including community and collective healing strategies from a mental health, social policy and justice perspective. A critical analysis of the following themes will be presented: reconciliation and the role of apology; forgiveness and acknowledgment; community healing and truth-telling; and the role of justice in healing. Examples will be drawn from the literature, using both theoretical and actual examples. Specifically, the interface of mental health, conflict and community will be elucidated and provide a platform for how the psychiatrist can operate in a post-war context.

REFERENCES:

1. Zwi A: Conflict and health: war and mental health: a brief overview. BMJ 2000; 321: 232–235.
2. World Health Organization: Declaration of Cooperation, Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations. Geneva, WHO, 2001.
3. Bolton P, Tang AM. Using ethnographic methods in the selection of post-disaster, mental health interventions. Prehospital Disaster Med 2004;19:97–101.
4. Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies Lancet 2004;364:2058–67.
5. Summerfield, D. A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Soc Sci Med 1999;48:1449–62.
6. Pham PN, Weinstein HM, Longman T. Trauma and PTSD Symptoms in Rwanda: Implications toward justice and reconciliation. JAMA 2004; 292: 602–612.

Symposium 7 **Friday, October 12 8:30 a.m.-11:30 a.m.**

CHALLENGES IN EMERGENCY PSYCHIATRY: QUESTIONS AND ANSWERS

American Association for Emergency Psychiatry

Avrim B. Fishkind, M.D., *President, American Association for Emergency Psychiatry; and Medical Director, Comprehensive Psychiatric Emergency Program of Harris County, Neuropsychiatric Center, 1502 Taub Loop, Houston, TX 77006*; Carla D. Edwards, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Define the key elements of training that all psychiatrists need in Emergency Psychiatry; 2.) Diagnose and treat the malingering patient in the emergency setting; 3.) Minimize the use of coercion and develop better therapeutic relationships with patients in crisis; and 4.) Identify current issues in assessing and documenting the suicidal and homicidal patient.

OVERALL SUMMARY:

In the first presentation, Dr. Rachel Glick will include the latest information on the model curriculum for training in issues related to psychiatric emergencies. She will cover suicidal and homicidal behaviors, prevention and management of aggressive behaviors and other key subjects. In the second presentation, Dr. Jon Berlin will discuss one of the most difficult to treat patients in the psychiatric emergency setting, namely the malingerer. He will explore how to view the malingerer in a new, less pejorative light, reframing the challenges as a form of therapeutic impasse which the clinician must overcome to form a therapeutic relationship with the patient. In the third presentation, ''Benefits of Avoiding Coercion in Psychiatric Emergency Settings,'' the lecturer will define coercive behaviors in acute psychiatric settings, explore the long-term implications of such coercive behaviors, and provide successful strategies for avoiding seclusion, restraint, and IM medications for aggression through the use of effective verbal de-escalation. In the fourth presentation, Dr. Scott Zeller will present the latest in the risk assessment of suicidal and homicidal ideation, including a look at the use of rating scales and medications for the prevention of suicide. There have been some rapid advancements in this area in conjunction with the American Association of Suicidology which will be presented. The pharmacologic approaches to anger and aggression will also be explored.

No. 7A
SUPERVISION BY PSYCHIATRIST IN THE PSYCHIATRIC EMERGENCY SETTING

Rachel L. Glick, M.D., *Clinical Associate Professor of Psychiatry, University of Michigan Medical School; and Past President, American Association for Emergency Psychiatry, 1663 Snowberry Ridge Road, Ann Arbor, MI 48103-9230*

SUMMARY:

In the first presentation, Dr. Rachel Glick will include the latest information on the model curriculum for train-

ing in issues related to psychiatric emergencies. She will cover suicidal and homicidal behaviors, prevention and management of aggressive behaviors and other key subjects.

No. 7B
MALINGERING AS THERAPEUTIC IMPASSE IN THE EMERGENCY SETTING

Jon S. Berlin, M.D., *Medical Program Director, Psychiatric Crisis Service, Milwaukee County Mental Health Division; Assistant Clinical Professor of Psychiatry, Medical College of Wisconsin; and Past President, Americn Association for Emergency Psychiatry, 9455 Watertown Plank Road, Milwaukee, WI 53226*

SUMMARY:

In the second presentation, Dr. Jon Berlin will discuss one of the most difficult to treat patients in the psychiatric emergency setting, namely the malingerer. He will explore how to view the malingerer in a new, less pejorative light, reframing the challenges as a form of therapeutic impasse which the clinician must overcome to form a therapeutic relationship with the patient.

No. 7C
BENEFITS OF AVOIDING COERCION IN PSYCHIATRIC EMERGENCY SETTINGS

Avrim B. Fishkind, M.D., *President, American Association for Emergency Psychiatry; and Medical Director, Comprehensive Psychiatric Emergency Program of Harris County, Neuropsychiatric Center, 1502 Taub Loop, Houston, TX 77006*

SUMMARY:

In this presentation, the lecturer will define coercive behaviors in acute psychiatric settings, explore the long-term implications of such coercive behaviors, and provide successful strategies for avoiding seclusion, restraint, and IM medications for aggression through the use of effective verbal de-escalation.

No. 7D
RISK ASSESSMENT OF THE SUICIDAL AND HOMICIDAL PATIENT IN THE PSYCHIATRIC EMERGENCY SETTING

Scott L. Zeller, M.D., *Psychiatric Emergency Services, Alameda County Medical Center, 2060 Fairmont Drive, San Leandro, CA 94578*, Ikechi C. Nnawuchi, M.D., *15212 Baileys Lane, Silver Spring, MD 20906*

SUMMARY:

In this presentation, Dr. Scott Zeller and Dr. Ikechi Nnawuchi will present the latest in the risk assessment of suicidal and homicidal ideation, including a look at the use of rating scales and medications for the prevention of suicide. There have been some rapid advancements in this area in conjunction with the American Association of Suicidology which will be presented. The pharmacologic approaches to anger and aggression will also be explored.

REFERENCES:

1. Kernberg, O. (1984) Severe Personality Disorders. New Haven: Yale University Press.
2. Ole J. Thienhaus and Melissa Piasecki. Emergency Psychiatry: Assessment of Psychiatric Patients' Risk of Violence Toward Others. Psychiatr. Serv., Sep 1998; 49: 1129–1147.
3. Segal SP, Laurie TA, Setal MJ. Factors in the Use of Coercive Retention in Civil Commitment Evaluations in Psychiatric Emergency Services. Psychiatr. Serv., Apr 2001:52: 514–520.
4. Cerel J, Currier GW, Conwell Y. Consumer and Family Experiences in the Emergency Department Following a Suicide Attempt. J. Psychiatr. Pract. 2006 Nov; 12(6):341–7.

Symposium 8 **Friday, October 12 8:30 a.m.-11:30 a.m.**

CREATING THE ENVIRONMENT: THE ROLE OF PSYCHOEDUCATION IN RECOVERY
Therapeutic Education Association

Karen A. Landwehr, M.A., *Clinician and Educator, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*; Larry S. Baker, M.A., *Director of Training, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the role of psychoeducation in creating a community environment that promotes recovery from mental illness, and state the issues and strategies relevant to developing recovery-oriented psychoeducation programs.

OVERALL SUMMARY:

This symposium will focus on the role of psychoeducation in creating and fostering recovery. The development of psychoeducation as a therapeutic intervention will be described, as will its use as a therapeutic interven-

tion for individual patients and family members. The need for psychoeducation programs for the general community and their potential role in creating an environment conducive to recovery will be discussed. Having considered the role of psychoeducation within the American mental health system, participants will be provided information about current developments in psychoeducation within the global community.

No. 8A
THE STATUS OF PSYCHOEDUCATION AS A RECOVERY STRATEGY

Cynthia C. Bisbee, Ph.D., *Former Clinical Director, Montgomery Area Mental Health Authority, 484 Farmington Lane, Pike Road, AL 36064*; Karen A. Landwehr, M.A.

SUMMARY:

Psychoeducation has been in use for nearly three decades as an important part of the overall treatment plan for serious mental illness, and has evolved into its present-day status as an evidence-based intervention. This presentation will trace the development of psychoeducation over the past two and one-half decades, from rudimentary nurse-led medication groups to comprehensive programming for both consumers and families. Included will be a description of the evolution of the definition of psychoeducation and an overview of various models and methods, including the SAMHSA psychoeducation toolkits.

No. 8B
THE ROLE OF PATIENT PSYCHOEDUCATION IN PSYCHIATRIC RECOVERY

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, 249 Lakewood Circle, Sylacauga, AL 35150*

SUMMARY:

Psychoeducation has gained prominence in recent years as an evidence-based service that can be provided by all members of the treatment team across every level of care. This presentation will identify reasons for doing patient psychoeducation, potential outcomes that can be measured, ways psychoeducation can be incorporated into individual sessions, and a method for determining staff competence to provide this service in classroom settings.

No. 8C
TAILORING GROUP PSYCHOEDUCATION TO STAGES OF RECOVERY FROM MENTAL ILLNESS

Harriet P. Lefley, Ph.D., *Professor, Department of Psychiatry, University of Miami School of Medicine, D-29, P.O. Box 016960, Miami, FL 33101*; Larry S. Baker, M.A.

SUMMARY:

The content and techniques of evidence-based family psychoeducation are applied in a major medical center, in two open-ended ongoing support groups. One is primarily for persons with serious mental illness, with some family attendance. The other is primarily for family members. Free and open to the public, the groups are highly representative of people with serious mental illness currently in the mental health system, with major axis I diagnoses and varying stages of recovery. Group process is the mediating factor in the absorption and application of psychoeducational learning. The presentation focuses on the basic elements of patient and family psychoeducation and how they are utilized contextually in resolving current problems, alleviating depression and demoralization, and giving hope. Patients in advanced recovery and knowledgeable families act as role models, educators, problem-solvers and conveyors of new possibilities for participants. Case studies are presented to illustrate how psychoeducation for recovery is tailored to stages in the illness trajectory and conveyed through group process.

No. 8D
THE ROLE OF COMMUNITY PSYCHOEDUCATION IN CREATING A CLIMATE OF RECOVERY

Karen A. Landwehr, M.A., *Clinician and Educator, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

SUMMARY:

Recovery occurs within the context of a community. Yet often the community is less than supportive and may in fact be an obstacle. Stigma, low expectations and lack of support are often the result of lack of knowledge and understanding about mental illnesses. Drawing on fifteen years of experience in providing simultaneous consumer, family, provider and community psychoeducation, this presentation will examine the need to provide psychoeducation opportunities to the general community. The goals of community psychoeducation and resources needed for implementing a community program

will be discussed, as will the pros and cons of a simultaneous approach.

No. 8E
THE GLOBAL COMMUNITY: WHAT CAN IT TEACH US ABOUT RECOVERY AND HOW TO ACHIEVE IT?

Dale L. Johnson, Ph.D., *Professor Emeritus, Department of Psychology, University of Houston, 831 Witt Road, Taos, NM 87571*

SUMMARY:

Evidence-based treatments have revolutionized the treatment of serious mental illness and patients, professionals and families have come to think in terms of recovery. This presentation will review three fairly recent developments that have taken place in Europe and Asia. These are the Optimal Treatment Program (13 countries), Cognitive Behavior Therapy for Psychotic Behaviors (United Kingdom) and Sheltered Workshops (Japan). These all promote recovery. Some possible reasons for these having developed outside the USA will be given.

REFERENCES:

1. Team Solutions, Weiden PJ, Scheifler PL, et. al., Eli Lilly and Company, 1996, 3rd Edition 2005.
2. B. Treatment Collaboration: Improving the Therapist, Prescriber, Client Relationship, Diamond RJ and Scheifler PL, WW Norton & Company, 2007.
3. Lefley, H.P. (2002). Foreword. In W.R. McFarlane (ed.), Multifamily Groups in the Treatment of Severe Psychiatric Disorders (pp.xi–xiv). New York: Guilford Press.
4. Marsh, D. T., & Lefley, H. P. (2003). Family interventions for schizophrenia. Journal of Family Psychotherapy, 14, 47–67.
5. Baker, LS & Landwehr, KA (2006). Pebbles in the pond: Achieving Resilience in Mental Health. Gig Harbor, WA: Directions in Education, Training & Consultation.
6. Falloon, I. R. H., et al. (2004). Implementation of evidence-based treatment for schizophrenic disorders: two-year outcome. World Psychiatry, 3, 104–109.
7. Turkington, D., Kingdon, D., & Weiden, P. J. (2006). Cognitive behavior therapy for schizophrenia. American Journal of Psychiatry, 3, 365–373.

Symposium 9 **Friday, October 12**
8:30 a.m.-11:30 a.m.

SPECIAL ISSUES AROUND HIV AND MENTAL HEALTH
APA Committee on AIDS

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons; and Deputy Director, New York State Psychiatric Institute, 5355 Henry Hudson Parkway, West, Apt. 9-F, Bronx, NY 10471-2868*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) List the range of HIV-related neuropsychiatric and psychiatric disorders; 2.) Recognize the latest findings in HIV prevention and treatment issues; 3.) Learn how to help patients affected by HIV cope with their illness(es) during heightened periods of stress; and 4.) Demonstrate knowledge of the various roles of mental health providers on a treatment team in order to provide the best patient care.

OVERALL SUMMARY:

Louisiana ranked fifth highest in state AIDS case rates and New Orleans ranked sixth in AIDS cases in 2004. Now a year past Katrina, New Orleans and Louisiana continue to suffer a devastating toll in overall health and mental health. Mental health problems have soared. Yet the number of providers, the facilities to handle incoming patients, and the money to support HIV and mental health programs has not increased. Special Issues around HIV and Mental Health is a program designed for a multidisciplinary audience. It will address the growing concerns over increased stress, depression, anxiety, and post-traumatic stress disorder over the past year in individuals infected with and affected by HIV/AIDS. Presenters will also address the worsening of provider burnout, particularly in times of prolonged stress and ways in which providers can effect and promote better self and patient care. Presenters will also provide updates on the latest in HIV prevention and HIV psychiatry. Participants will have time for discussion, questions, and concerns throughout the program.

No. 9A
NEUROPSYCHIATRIC ASPECTS OF HIV

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

SUMMARY:

There are significant direct consequences to the invasion of HIV into the nervouse system that may present as neurological, neuropsychiatric, and/or psychiatric syndromes and disorders. These may arise acutely and require rapid evaluation and intervention or they may be chronic, subtle, and present accompanied by physical complaints. Dramatic changes in cognition, motor capacity, mood or behavior have obvious consequences for the individual. However, subtle neurocognitive impairments may affect coping mechanisms and the ability to work, adherence to HAART and medical care, and adherence to protective sexual pratices. Appropriate training is needed to assess, diagnose, and treat the neuropsychiatric sequelae of HIV disease. This presentation will focus on the treatment of psychiatric disorders in people with HIV and AIDS, with a focus on neuropsychiatric manifestations, psychiatric syndromes, and somatic complaints. Presenters will share their clininical experiences, focusing on the prevalence, clinical features, patient complaints, clinical course, differential diagnosis and treatment of these disorders.

No. 9B
PTSD AND HIV

Antoine B. Douaihy, M.D., *Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine; and Medical Director, Addiction Medicine Services, Western Psychiatric Institute and Clinic, 372 S. Highland Avenue, 602, Pittsburgh, PA 15206-5213*

SUMMARY:

Anxiety disorders are common throughout the spectrum of HIV infection. While PTSD may be diagnosed among any individuals with HIV infection who experience a significant life trauma, a PTSD syndrome has been specifically described among some individuals subsequent to their notification of HIV test results. Similarly, some individuals who have experienced the trauma of multiple AIDS-related losses experience a PTSD syndrome. The presenter will discuss clinical cases, review diagnostic criteria, and present treatment options for working with individuals living with HIV and Post-Traumatic Stress Disorder.

No. 9C
WHAT'S NEW IN HIV PREVENTION?

Milton L. Wainberg, M.D., *Associate Clinical Professor, Department of Psychiatry, Columbia University, 404 Riverside Drive, #5-B, New York, NY 10025-1861*

SUMMARY:

Mental health providers play a key role in educating their patients about effective ways to protect themselves from infection. This session will help providers increase their comfort level in providing information about harm reduction strategies and safer sex practices, while also reviewing the latest information in HIV prevention.

No. 9D
ADDRESSING PROVIDER BURNOUT

Khakasa H. Wapenyi, M.D., *356 West 18th Street, New York, NY United States 10011-4401*

SUMMARY:

Provider burnout severly impacts effective patient care. In areas where stigma is already great, HIV/AIDS and mental health, mental health care providers face even more of a burden following a natural disaster where finances, resources, and support systems are stretched to the limits as patients become more vulnerable and face higher levels of stress. This session offers innovative approaches for coping with provider burnout and creative solutions for building better systems and defining clearer roles.

REFERENCES:

1. Fernandez F. Neuropsychiatric aspects of human immunodeficiency virus (HIV) infection. Curr Psychiatry Rep. 2002 Jun;4(3):228–31.
2. Valente, FM. Depression and HIV disease. J Assoc Nurses AIDS Care. 2003 Mar–Apr;14(2):41–51.
3. Tresiman G, Angelino A. The Psychiatry of AIDS: A Guide to Diagnosis and Treatment. Baltimore, MD. The John Hopkins University Press, 2004.
4. HIV/AIDS: The Brain and Behavior, A Multidisciplinary Mental Health Services Curriculum. Center for Mental health Services/ADMA. Rockville, MD, 2003.
5. Fernandez, F. Ten myths about HIV infection. FOCUS. The Journal of Lifelong Learning in Psychiatry. Spring 2005, Vol. III, No. 2.
6. Tresinman G, Angelino A. The Psychiatry of AIDS: A Guide to Diagnosis and Treatment. Baltimore, MD. The John Hopkins University Press, 2004.

Symposium 10 — **Friday, October 12, 8:30 a.m.-11:30 a.m.**

HURRICANE KATRINA: RESPONDING TO MENTAL HEALTH NEEDS IN AN UNPRECEDENTED DISASTER

Health Services Research Track

Harold Goldstein, Ph.D., *Director, Program Evaluation and Special Projects, Division of Research/APIRE,*

American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3924

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the implications of major natural disasters for meeting the mental health needs of vulnerable populations.

OVERALL SUMMARY:

Hurricane Katrina was the costliest natural disaster in U.S. history, with much of New Orleans, Plaquemines, and St. Bernard Parish destroyed. With the concomitant destruction of the mental health infrastructure , the barriers to meeting the needs of vulnerable populations in crisis were enormous. This symposium will address the "on the ground" responses of various mental health institutions and resources, their approaches to this unprecedented disaster, and the data emerging on the impact of the disaster on mental health needs and outcomes. Additionally, the symposium will address the issues involved in preparing for the provision of mental health care in such disasters and the research needed to improve the effectiveness of mental health disaster response.

No. 10A
MEETING MENTAL AND EMOTIONAL NEEDS FOLLOWING HURRICANE KATRINA

Howard J. Osofsky, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Louisiana State University Health Sciences Center, 2020 Gravier Street, New Orleans, LA 70112-2865*

SUMMARY:

Hurricane Katrina resulted in a disaster of proportions not previously known in the United States. The traumatic experiences of children and families during Hurricane Katrina, the flooding that resulted from the breech of the levees, the evaluation and the aftermath are unprecedented. Dr. Osofsky will focus on addressing the mental and emotional needs of the people of New Orleans during and after this disaster.

No. 10B
TRAINING TEACHERS AND OTHER INDIGENOUS PROFESSIONALS TO HELP TRAUMATIZED CHILDREN

S. Arshad Husain, M.D., *Professor, Department of Psychiatry, University of Missouri, 1 Hospital Drive, Room 119, Columbia, MO 65201-5276*

SUMMARY:

This presentation will discuss the application of the Teachers as Therapists (TAT) Model in New Orleans following Hurricane Katrina. Resulting from the disparity between people requiring psychological help and the mental health professionals available to provide it in times of disaster, this model of training indigenous professionals in trauma psychiatry was developed over 12 years in 13 different countries. TAT is a program which transforms psychiatric methods into elemental programs for non-mental health professionals, primarily teachers. Teachers were selected as a primary resource for training because of their close contact with children, their ability to discern normal from abnormal behaviors, and their experience in reshaping behaviors. Currently, more than 6,000 teachers and other indigenous professionals have been trained through TAT to provide mental health disaster assistance. In this presentation, the application of the model in New Orleans and the experiences in implementing it will be discussed.

No. 10C
LESSONS LEARNED: WHAT MENTAL HEALTH SERVICES WERE NEEDED AFTER KATRINA?

Grayson S. Norquist, M.D., *Professor and Chair, Department of Human Behavior, University of Mississippi Medical Center, 2500 N. State Street, Jackson, MS 39216-4500*

SUMMARY:

This presentation will provide an overview of "on-the-ground" experience delivering mental health services in the Mississippi Gulf Coast area following Hurricane Katrina. Initially, the presentation will briefly outline prior disaster-related research and its projected implications for the types of mental health services needed after disasters such as Katrina. It will then present data on the types of mental health needs that actually arose in the Mississippi Gulf Coast area after Katrina, and the services that were actually needed. Data from community surveys and Project Recovery will be described. Examples of what was learned from Katrina will also be presented so that more effective preparations for mental health services after such a disaster can be implemented. Finally, the presentation will address the research needed to enhance our ability to design better post-disaster services, especially for populations that are not traditionally considered (e.g., elderly).

No. 10D THE USE OF MENTAL HEALTH SERVICES BY VULNERABLE SURVIVORS OF HURRICANE KATRINA

Philip S. Wang, M.D., *Director, Division of Services and Intervention Research, National Institute of Mental Health, 6001 Executive Boulevard, Bethesda, MD 20892-0001*

SUMMARY:

This presentation will report the results of a survey on the use of mental health services by vulnerable survivors of Hurricane Katrina, the costliest natural disaster in the United States, and on the array of barriers limiting the timely provision of care to these populations. A geographically-representative telephone survey was conducted between January 19, and March 31, 2006 of 1,043 displaced and non-displaced, English-speaking Katrina survivors 18 years of age and older who resided in affected areas before the hurricane. Survivors with 30-day serious, mild-moderate, and no apparent mental disorders were identified with the K-6 scale. Use of mental health services, specific sectors, treatment modalities, and reasons for not seeking treatment or dropping out of treatments were recorded. Correlates of using services and dropping out of treatments were examined. Only 31.5% of Katrina survivors with active mental disorders used any mental health services following the disaster, including 46.5% of those with SMI. Of those that used services, 60.5% dropped out by the time of interview. The general medical sector and pharmacotherapies were most commonly used, although the specialty sector and psychotherapies play important roles especially for survivors with SMI. Many treatments were of low intensity and frequency. Undertreatment was greatest among the young, old, never married, racial or ethnic minorities, uninsured, and those with moderate levels of means. Structural, financial, and attitudinal barriers were frequent reasons for foregoing care. This survey documented the profound unmet needs that exist among Hurricane Katrina survivors burdened by mental illness. Future disaster management plans should anticipate the needs of this large and vulnerable population, with timely provision of services and resources to address financial, structural, and attitudinal barriers.

REFERENCES:

1. Husain, SA, & Anderson, W. "Treating Trauma: Lessons from the Field." University of Missouri Peace Studies Review (Fall Issue 2005) Volume 1, Number 2: 63–73.
2. Husain, SA. "The Experience of Bosnia-Herzegovina: Psychological Consequences of War Atrocities on Children." In Disasters and Mental Health. John Wiley & Sons. (2005).
3. Husain, SA, Nair, J, Holcomb, W, Reid, JC, Vargas, V, & Nair, SS. "Stress Reactions of Children and Adolescents in War and Siege Conditions." The American Journal of Psychiatry (1998): 155, 1718–1719.
4. Ursano RJ, Cerise FP, Demartino R, Reissman DB, Shear MK. The Impact of Disasters and Their Aftermath on Mental Health. Prim Care Companion J Clin Psychiatry. 2006;8(1):4–11.
5. Weisler RH, Barbee JG 4th, Townsend MH. Mental health and recovery in the Gulf Coast after Hurricanes Katrina and Rita. JAMA. 2006 Aug 2;296 (5):585–8.
6. U.S. Department of Homeland Security. Hurricane Katrina: what government is doing. Available at: http://dhs.gov/interweb/assetlibrary/katrina.htm.
7. Rosenbaum S: U.S. health policy in the aftermath of Hurricane Katrina. JAMA 2006; 295:437–440
8. Kessler RC, Galea S, Jones RT, Parker HA: Mental illness and suicidality after Hurricane Katrina. Bull World Health Organ, In Press.

Symposium 11 **Friday, October 12 2:00 p.m.-5:00 p.m.**

TAKING IT TO THE NEXT LEVEL: BEST PRACTICES IN THE TREATMENT OF THE MENTALLY ILL HOMELESS PERSON

APA Corresponding Committee on Poverty, Homelessness, and Psychiatric Disorders

Jeffrey G. Stovall, M.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 72 Jaques Avenue, Worcester, MA 01610-2476*; Annelle B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate a knowledge of current approaches to providing psychiatric treatment to individuals who are homeless and mentally ill, and recognize obstacles to implementing best practices.

OVERALL SUMMARY:

Over the past twenty years there have been many descriptions of the problem of homelessness, and of mentally ill people who are homeless. A variety of programs and treatment approaches have been tried, yet serious mental illness among individuals who are homeless persists at rates between one third to one half. In this symposium, clinicians with years of experience will discuss the state of the art practices for the treatment and rehabilitation of mentally ill homeless persons. Individual lectures will include: 1.) Approaching the concept of best practices; 2.) The clinical art of engagement

with a mentally ill homeless person; 3.) The role of the psychiatrist on the multidisciplinary team providing care to mentally ill homeless people; 4.) The psychiatrist as advocate; and 5.) The art of prescribing medication for a homeless, mentally ill person. These talks will focus on developing a structure for rehabilitation-engagement, intensive care, and ongoing rehabilitation and the pivotal role the psychiatrist plays in the treatment. The goal of this symposium is to educate the participant about current best practices for individuals who are homeless and mentally ill, and to move towards a consensus on what constitutes best practice.

No. 11A
APPROACHING THE CONCEPT OF BEST PRACTICES IN TREATING MENTALLY ILL HOMELESS PEOPLE

Hunter L. McQuistion, M.D., *Clinical Director, Division of Integrated Services, and Department of Psychiatry, St. Luke's-Roosevelt Hospital; and Former APA/Bristol-Myers Squibb Fellow, 107 Pinecrest Parkway, Hastings on Hudson, NY 10706-3703*

SUMMARY:

Over the past twenty years there have been many descriptions of the problem of homelessness, and of mentally ill people who are homeless. A variety of programs and treatment approaches have been tried, yet serious mental illness among individuals who are homeless persist at rates between one third to one half. During the same time period the concept of best practices has emerged in a number of medical fields including psychiatry. This presentation will combine these two concepts and argue the value of developing and employing best practices in the treatment of mentally ill homeless people. The goal of this presentation is to educate the participant about current best practices for individuals who are homeless and mentally ill, and to move towards a consensus on what constitutes best practices. The presentation will be of interest and benefit to psychiatrists working with homeless, mentally ill persons, residents and medical students, and administrators and policy makers who design and manage treatment programs.

No. 11B
THE ART OF ENGAGEMENT: WORKING WITH A MENTALLY ILL HOMELESS PERSON

Anthony T. Ng, M.D., *Psychiatrist, Health Care for the Homeless Mental Health, 111 Park Avenue, Baltimore, MD 21202*

SUMMARY:

Treatment approaches for providing services for mentally ill, homeless persons all identify engagement as a key and difficult step. This presentation will focus on the clinical art of engaging a mentally ill, homeless person into treatment, identifying obstacles to engagement and techniques and skills to use in engagement. The goal of this presentation is to educate the participant about the difficulty and importance of engagement, and methods for approaching this problem. This presentation will be of interest to psychiatrists, residents and medical students working with mentally ill, homeless persons.

No. 11C
THE ROLE OF A PSYCHIATRIST ON A MULTIDISCIPLINARY TEAM PROVIDING SERVICES TO INDIVIDUALS WHO ARE HOMELESS

Toi B. Harris, M.D., *Assistant Professor of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*

SUMMARY:

Services to mentally ill, homeless persons are often provided by multidisciplinary mental health teams that may include nurses, therapists, outreach workers, housing specialists and others in addition to a psychiatrist. The psychiatrist plays a role in not only directly providing psychiatric care, but also serves to help the team develop an overall and individualized treatment plan. Given the depth of training a psychiatrist has undergone, the psychiatrist is also able to assist the team in both the countertransference reactions to treating individuals who are homeless and mentally ill. Finally, the psychiatrist often serves as the liason or ambassador to medical clinics and emergency rooms, social services and benefits agencies, and the courts. The goal of this presentation is to educate the participant as to the broad role of a psychiatrist in providing treatment to mentally ill, homeless persons. The presentation will be of interest to psychiatrists working on multidisciplinary teams, other professionals who work with mentally ill, homeless persons, and administrators and policy makers who design these services.

No. 11D
WORKING IN A BEWILDERING SYSTEM OF CARE: THE PSYCHIATRIST AS ADVOCATE

Neil A. Falk, M.D., *Associate Medical Director, Cascadia Behavioral Health Care, 2415 S.E. 43rd Avenue, Portland, OR 97206-1602*

SUMMARY:

A person who is homeless and mentally ill must negotiate a myriad of social services agencies, shelters, health care providers, the police and courts, and government entitlements if their treatment and rehabilitation is to be successful. A primary role for the multidisciplinary team working with people who are homeless and mentally ill can be engaging the person in working with these systems, and assisting in the successful negotiations of the complex and often hostile systems. The psychiatrist on the multidisciplinary team is able to use their unique combinations of clinical expertise and authority to advocate for the homeless, mentally ill person with the courts, and with medical providers in obtaining entitlements. This presentation discusses the methods for serving as an advocate by the psychiatrist, and identifying and avoiding obstacles to successful advocacy. Psychiatrists and residents will find this presentation informative, as will administrators and policy makers who work in programs that serve people who are homeless and mentally ill.

No. 11E
BALANCING SCIENCE AND ART: PRESCRIBING MEDICATIONS FOR THE MENTALLY ILL HOMELESS PERSON

Ann L. Hackman, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21201*

SUMMARY:

People who are homeless and mentally ill often have a complex mix of medical illnesses, psychiatric illnesses and addictions. In the most stable of circumstances, prescribing psychiatric medications in a safe and effective manner is challenging for individuals with this severity of multiple illnesses. With a person hesitant to engage in treatment and without the residential stability that allows for improved adherence to medication schedules, prescribing is an intricate balance of acceptance, potential side effects, drug interactions and delivery. This presentation focuses on the art of prescribing, of combining these conflicting and challanging factors into a prescribing approach. This presentation will benefit psychiatrists, residents and medical students who work with mentally ill, homeless people.

REFERENCES:

1. Ng AT, McQuistion HL: Outreach to the homeless: craft, science, and future implications. Journal of Psychiatric Practice 10:95–105, 2004.
2. Stein LI: The community psychiatrist: skills and personal characteristics. Community Mental Health Journal 34:437–445, 1998.
3. Falk N. General concepts of outreach and engagement, in Clinical Guide to the Treatment of the Mentally Ill Person. Edited by Gillig PM, McQuistion HL. Washington, DC, American Psychiatric Press, 2006.
4. McQuistion HL, Felix A, Susser ES: Serving homeless people with mental illness, in Psychiatry, 2nd edition. Edited by Tasman A, Lieberman J, Jay J. London, Wiley, 2003, p2314–2321.

Symposium 12 **Friday, October 12 2:00 p.m.-5:00 p.m.**

CRISIS IN THE COMMUNITY: HOW DO WE RESPOND?

Therapeutic Education Association

Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*; Karen A. Landwehr, M.A., *Clinician and Educator, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the effect of trauma and violence on police officers and crises responders and how to lessen the negative impact of traumatic experiences through advance planning, training, and ongoing support; and discuss the effect media coverage of traumatic events has on vulnerable patients.

OVERALL SUMMARY:

This symposium will look at the issue of trauma and violence and how they affect both crisis responders and mentally ill patients. A model for collaboration between police and mental health providers will be described. The impact of traumatic experiences on responding police officers will be discussed, along with ways to help police officers deal with the psychiatric symptoms they experience. Recommendations for training crises intervention and crisis line workers will be provided. Participants will have an opportunity to discuss the effect media coverage of traumatic events has on psychiatric patients and to explore the idea that psychosis in inherently traumatic.

No. 12A
RESPONDING TO CRISES: THE PSYCHIATRIC EFFECTS ON POLICE OFFICERS

Chief Joseph Mokwa, *Chief of Police, St. Louis Police Department, 1200 Clark Avenue, St. Louis, MO 63103*

SUMMARY:

This presentation will provide insight into the experiences of St. Louis, Missouri, police officers in their role as first responders in crisis situations. Information about the training officers receive to help de-escalate crisis situations will be presented, along with a description of the training provided to help officers develop positive mechanisms for coping with conflicts/traumatic events will be provided and the physical and emotional impact such events have on the responding officers and their family members will be described. Other factors affecting the mental health of police officers will be discussed, as well as the procedures in place to provide support for officers following traumatic experiences. The collaborative relationship between the St. Louis Police Department and local mental health professionals will be discussed, along with ways to improve communication between the two systems.

No. 12B
HOW CAN WE WORK TOGETHER? COORDINATING MENTAL HEALTH AND CRISIS FIRST RESPONSE EFFORTS

Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*

SUMMARY:

Much has been written about the various kinds of psychiatric intervention and services that need to be provided to victims of trauma, either man made or natural. That will not be the subject of this presentation. Instead, it will be one man's opinion of how first responders, typically police and other emergency management personnel, and the psychiatric community have to work together on a practical level. This is based on experiences with debriefing after the TWA flight 800 disaster a few years ago and communications with police over matters ranging from involuntary admissions to education about psychiatric illnesses. It will be a how to, hands on presentation. How to work with the police. How to understand their problems. How to be mindful of the constraints they feel and letting them know as well the limitations of our profession.

No. 12C
TRAINING INDIVIDUALS FOR CRISIS TELEPHONE AND OUTREACH INTERVENTIONS

Larry S. Baker, M.A., *Director of Training, Tacoma Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

SUMMARY:

Providing effective intervention in psychiatric emergencies is a team effort. Members of the team, especially volunteers and para-professionals often require training in the basics of the work they will be called upon to initiate. Others benefit by regular review and update of previous learning. Persons in crisis, whether the victim, family members or bystanders have affective and cognitive shifts in awareness, presenting numerous communication challenges. Initial response, whether by telephone or face to face interview, is a major determinant of outcomes. Issues of rapport and trust building, information gathering and documentation and determining subsequent steps will be addressed. Control by the intervenor of the environment when possible, maintaining confidentiality and decisions about seeking consultation and supervision will be visited. This presentation summarizes the training needs of first line responders and equips participants for their major roles in the curriculum development and delivery of effective training. Attendees will also hear suggestions about building community networks related to crisis intervention services.

No. 12D
(BLANK) HAPPENS: ARE WE TRAUMATIZED OR TRAUMATIZING?

Karen A. Landwehr, M.A., *Clinician and Educator, Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

SUMMARY:

Building upon the other presentations in the symposium, this presentation will invite participants to consider whether our culture and we as psychiatrists or therapists contribute to an atmosphere of fear. The issue of vicarious trauma will be discussed, and participants will have an opportunity to develop a list of traumatic experiences that may trigger responses in previously traumatized individuals. Participants will be challenged to consider the experience of a psychotic episode from the standpoint of their patients and whether experiencing psychosis should be considered inherently traumatic. This will be a highly interactive presentation. Participants will be asked to share their own experience of watching traumatic events occurring in the news, on television or in movies and discuss how such vicarious experiences of trauma may affect individuals who are vulnerable to trauma. They will be asked to describe the experiences of psychotic patients and how that experience may or May not be sufficiently severe to produce Post-Traumatic Stress Disorder. Finally, they will be asked to identify ways in which their practice needs to change in order to: 1.) Help patients who experience vicarious trauma; 2.) Help patients experiencing psychosis avoid

developing PTSD; and 3.) Avoid further traumatizing already traumatized patients.

REFERENCES:

1. Elkins A. M. & Papanek G. O. Consultation with the police: an example of community psychiatry practice. Am J Psychiatry 123:531–535, November 1966.
2. Sloan, M. (2000). Response to media coverage of terrorism. Journal of Conflict Resolution, 44, 508–522.
3. Joseph J. Zealberg, J. J., Hardesty, S. J. & Tyson, S. C. Emergency psychiatry: mental health clinician's role in respondeing to critical incidents in the community. Psychiatric Services 49:301–303, March 1998.
4. Roberts, AR, Crisis intervention handbook: assessment, treatment and research (3rd edition). New York: Oxford University Press, 2005.
5. Schuster, M.A., Stein, B.D., Jaycox, L.H., Collins, R.L., Marshall, G.N., Elliott, M.N., et.al. (2001). A National Survey of stress reactions after the September 11, 2001 terrorist attacks. New England Journal Medicine, 345, 1507–1512.

Symposium 13 **Friday, October 12 2:00 p.m.-5:00 p.m.**

ADDRESSING WELLNESS IN RECOVERY PERSONNEL AND THEIR FAMILIES

OMNA on Tour in the Gulf Coast Track

Elliott Hill, L.C.S.W., BCD, *Consultant, E. Hill & Associates, LLC, 2221 Peachtree Road, Suite D-178, Atlanta, GA 30309*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Identify specific considerations using volunteer behavioral health teams to provide wellness services (i.e., orientation, assessment of strengths, confidentiality, protocols, etc.); 2.) Create a "Flexible and site specific Wellness Center" and other creative ideas for meeting the special needs of disaster recovery personnel; 3.) Market the wellness services to disaster recovery workers; and 4.) Recognize the lessons learned from the experience of using volunteer behavioral health teams to provide wellness services.

OVERALL SUMMARY:

This presentation will explain the use of volunteer mental health teams deployed for crisis counseling to provide services to disaster responders. These mental health crisis workers responded to the needs of the local behavioral health workers, Emergency Operations Center personal, Disaster Recovery Center Staff and local city/government workers in New Orleans after Katrina.

No. 13A
CREATING A WELLNESS CENTER AS PART OF AN EMERGENCY OPERATION CENTER (EOC): FROM CONCEPT TO REALITY

Sandra Williams-Ortega, Ph.D., *Consultant, 44 Merion Road, Marlton, NJ 08053*

SUMMARY:

This presentation describes the process used to develop a Wellness Center in the New Orleans Emergency Operations Center, after Katrina, focusing on strategies needed to create and implement a Wellness Center for disaster recovery personnel. This process includes: 1.) Defining a comprehensive recovery approach to wellness management and life re-balancing; 2.) Marketing and promoting a wellness center concept as a direct approach rather than a fringe addition to medical and mental health regeneration; 3.) Approaching wellness from a holistic, "less to more" perspective beginning with non-stigma inducing alternative health methodologies; 4.) Determining what personnel and logistical resources are needed for an effective service delivery system and acquiring them; and 5.) Creating and sustaining community "ownership" for center acceptance, promotion, and support.

No. 13B
PROVIDING WELLNESS SERVICES TO DISASTER RESPONDERS USING DEPLOYED MENTAL HEALTH PROFESSIONALS

Elliott Hill, L.C.S.W., BCD, *Consultant, E. Hill & Associates, LLC, 2221 Peachtree Road, Suite D-178, Atlanta, GA 30309*

SUMMARY:

This presentation will focus on specific considerations using volunteer behavioral health teams to provide wellness services (i.e., orientation, assessment of strengths, confidentiality, protocols, etc.). It will address how to create a "Flexible and site specific Wellness Center" and other creative ideas for meeting the special needs of disaster recovery personnel. How to market the wellness services to disaster recovery workers will also be addressed, along with lessons learned from the experience of using volunteer behavioral health teams to provide wellness services.

No. 13C
EXPANDING THE DEFINITION OF FIRST RESPONDERS AND DISASTER RESPONSE PERSONNEL TO PROACTIVELY ADDRESS THEIR WELLNESS NEEDS

Nancy Burris Perret, *Consultant, 68 Ravine Lane, Poplarville, MS 39470*

SUMMARY:

Emergency response plans typically include mental health resources for "first responders", identified as police, fire and EMS personnel. However, addressing the total wellness of ALL recovery personnel and their families and other support systems is essential to their ability to continue serving the needs of the affected community in disaster settings. This presentation defines the needs that emerged in the New Orleans Emergency Operations Center and the comprehensive physical and behavioral health services that were organized to meet these needs.

No. 13D
STUDYING GRIEF IN BEHAVIORAL HEALTH STAFF: CARING FOR OTHERS WHILE RECOVERING FROM DISASTER

Jacquelyn A. Robinson, M.D., *Interim Medical Director, Metropolitan Human Services District, 1516 Third Street, New Orleans, LA 70130*

SUMMARY:

The adverse impact of trauma work on mental health care providers is consistently acknowledged in the psychiatric literature. However, less is known when the helpers are also the survivors of the disaster. What is the impact of trauma work on mental health care providers in this unique category? Clinical vignettes and data from structured interviews from the behavioral health care staff of the Metropolitan Human Services District (public outpatient behavioral health system for Orleans, Plaquemines, and St. Bernard Parishes/Counties) are presented with implications for a better understanding of the psychological aftermath of disaster in this community.

REFERENCES:

1. Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.F., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. St. Louis, MO: Department of Veterans Affairs Employee Education System, National Media Center.
2. Center for Mental Health Services. Stress prevention and management approaches for rescue workers in the aftermath of terrorist acts. 2005. Retrieved May 19, 2005, from http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/stress.asp.
3. Young, B.H. (2006). The immediate response to disaster: Guidelines for adult psychological first aid. In E.C. Ritchie, P.J. Watson, & M.J. Friedman (Eds.), Interventions following mass violence and disasters, (pp.134–154). Guilford Press. New York.
4. Flynn, B. W. (Brian W.) Mental health all-hazards disaster planning guidance Rockville, Md. U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2003.
5. Boscarino JA, Figley CR, Adams RE: Compassion fatigue following the September 11 terrorist attacks: a study of secondary trauma among New York City social workers. Int J Emerg Ment Health. 2004 Spring; 6(2):57–66.
6. Cowen, EL. Cowen, EL. The enhancement of psychological wellness: challenges and opportunities. Am J Community Psychol. 1994 Apr;22(2):149–79.
7. Adams RE, Boscarino JA, Galea S. Social and psychological resources and health outcomes after the World Trade Center Disasters Sci Med. 2006 Jan; 62(1):176–88.
8. Boscarino JA, Adams RE, Foa EB, Landrigan PJ. A propensity score analysis of brief worksite crisis interventions after the World Trade Center disaster: implications for intervention and research. Med Care. 2006 May; 44(5):454–62.
9. Federal Emergency Management Agency. (2005). IS700 NIMS course summary. Retrieved May 18, 2005, from http://www.training.fema.gov/EMIWeb/downloads/ IS700-NIMS.pdf.

Symposium 14 **Friday, October 12 2:00 p.m.-5:00 p.m.**

CO-MORBIDITY IN THE COURSE OF HIV INFECTION
APA Committee on AIDS

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Define the neuropsychiatric and psychiatric aspects of HIV/AIDS; 2.) Recognize emerging HIV-related mental health concerns; and 3.) Discuss diagnostic and treatment concerns as they relate to HIV/AIDS and mental health.

OVERALL SUMMARY:

As of 2004, it was estimated that over 24,000 people were living with HIV/AIDS in Louisiana. People of color and women and children are particularly vulnerable to infection. New cases of HIV infection continue to rise significantly. Yet receiving assistance has become even more challenging following last year's hurricane. Stress levels are higher creating even more challenges for already vulnerable populations. The mental health of people living with HIV has become an even greater concern. Co-morbid medical, mental, and substance use disorders are common among people living with HIV. The purpose, co-morbidity in the Course of HIV Infection, is to provide a forum for psychians to understand and better assess and treat psychiatric aspects of HIV. Presenters will review the diagnostic and treatment criteria associated with the neuropsychiatric aspects of HIV. Presenters will also delve more deeply into Triple Diagnosis, Psychosis and HIV, and Hepatitis C and HIV co-infection. A question and answer period will provide time for participants to raise clinical concerns and review cases.

No. 14A
NEUROPSYCHIATRIC ASPECTS OF HIV

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

SUMMARY:

There are significant direct consequences to the invasion of HIV into the nervous system that may present as neurological, neuropsychiatric, and/or psychiatric syndromes and disorders. These may arise acutely and require rapid evaluation and intervention or they may be chronic, subtle, and present accompanied by physical complaints. Dramatic changes in cognition, motor capacity, mood or behavior have obvious consequences for the individual. However, subtle neurocognitive impairments may affect coping mechanisms and the ability to work, adherence to HAART and medical care, and adherence to protective sexual practices. Appropriate training is needed to assess, diagnose, and treat the neuropsychiatric sequelae of HIV disease. This presentation will focus on the treatment of psychiatric disorders in people with HIV and AIDS, with a focus on neuropsychiatric manifestations and psychiatric syndromes. The presenter will share his clinical experiences, focusing on the prevalence, clinical features, patient complaints, clinical course, differential diagnosis and treatment of these disorders.

No. 14B
PSYCHOSIS AND HIV

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons; and Deputy Director, New York State Psychiatric Institute, 5355 Henry Hudson Parkway, West, Apt. 9-F, Bronx, NY 10471-2868*

SUMMARY:

Psychotic disorders may be more prevalent in those with HIV infection than in the general population. Estimates of the prevalence of new onset psychosis in HIV-infected patients vary widely, from less than .5% to 15%. Common risk factors for psychosis in those with HIV infection include: stimulant and sedative/hypnotic abuse/dependency, CNS opportunistic illness, other medical illness, prescribed medications, and prior history of psychotic disorder. The session will cover the course of psychosis in HIV infection, differential diagnosis, causes and treatment with ample time to address clinical concerns and questions.

No. 14C
TRIPLE DIAGNOSIS: SUBSTANCE USE, MENTAL HEALTH, AND HIV

Antoine B. Douaihy, M.D., *Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine; and Medical Director, Addiction Medicine Services, Western Psychiatric Institute and Clinic, 372 S. Highland Avenue, Room 602, Pittsburgh, PA 15206-5213*

SUMMARY:

Substance use disorders and psychiatric illness commonly co-occurs in what is known as "dual diagnosis." With the spread of HIV in dually diagnosed individuals, the "triple diagnosis" has emerged as a clinically challenging condition for primary care physicians, addiction medicine specialist, and psychiatrists. Existing data support the high prevalence of triple diagnosis patients in psychiatric, substance abuse, and HIV treatment settings. This session highlights the features of the triple diagnosis and the complex challenges of treating patients with triple diagnosis. Using a case presentation, the psychiatric, psychosocial, and substance use issues to triple diagnosis are discussed. The various psychosocial and psychopharmacological strategies in the case context are explored, emphasizing the importance of an integrated approach to treatment. The audience is encouraged to participate actively in discussion and share their thoughts and experiences in working with patients with triple diagnosis.

No. 14D
HEPATITIS C AND HIV

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons; and Deputy Director, New York State Psychiatric Institute, 5355 Henry Hudson Parkway, West, Apt. 9-F, Bronx, NY 10471-2868*; Marshall Forstein, M.D.; Antoine B. Douaihy, M.D.

SUMMARY:

Infection with hepatitis C can worsen the deficits in brain function caused by HIV disease. It is speculated that the hepatitis C virus may cause damage to brain cells and bring about cognitive impairment, by infecting cells within the brain itself. Alternatively, the virus could infect cells that move into the brain from the blood, where it could increase the rate of HIV replication. What is clear is that hepatitis C virus may cause major cognitive impairment among those infected and increase HIV morbidity. And because the majority of hepatitis C virus-infected adults have additional risk factors for cognitive impairment such as drug or alcohol abuse or HIV infection, the prevalence of cognitive impairment among these persons may be disconcertingly high. During this session, participants will review the medical and psychiatric dim,ensions of the dual epidemic of hepatitis C and HIV, including the effects of antiviral therapy on cognitive functioning, psychopharmacology with impaired liver function, and the psychology of addiction and sobriety issues.

REFERENCES:

1. Fernandez, Francisco. Psychiatric Aspects of HIV/AIDS. Philadelphia. Lippincot Williams and Wilkins, 2006.
2. Citron, Kenneth. HIV and Psychiatry: A Training and Resource Manual. London. Cambridge University Press, 2005.
3. Armstrong, W., Calabrese, L., Taege A. HIV update 2005: origins, issues, prospects, and complications. Cleveland Clinical Journal of Medicine, Vol. 72, No. 1, 2005.
4. American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium. Practice guidelines for the treatment of patients with HIV/AIDS. Arlington, VA, American Psychiatric Association, 2004, pp 155–2.
5. Atlas A, et.al. Acute Psychotic Symptoms in HIV-1 Patients are Associated with Increased Levels of Kynurenic Acid in Cerebrospinal Fluid. Brain Behav Immun. 2006 Apr 5.
6. Chander G et.al. Substance abuse and psychiatric disorders in HIV-positive patients: epidemiology and impact on antiretroviral therapy. Drugs. 2006;66 (6):769–89.
7. Preau M. Health Related Quality of Life Among HIV-HCV Co-infected Patients. Rev Epidemiol Sante Publique. 2006 Jul;54(HS1):33–43.

Symposium 15 **Saturday, October 13**
8:30 a.m.-11:30 a.m.

SANCTITY AND SANITY IN THE FACE OF DISASTER
OMNA on Tour in the Gulf Coast Track

Toi B. Harris, M.D., *Assistant Professor of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*; Michael A. Torres, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Analyze current literature describing these partnerships; 2.) Describe protective factors associated with religiosity; and 3.) Discuss treatment and systems of care implications.

OVERALL SUMMARY:

Emotional support was rendered by numerous faith-based initiatives in the aftermath of Hurricanes Katrina and Rita. Information gathered by the National Institute of Mental Health (2005) notes that people seek mental health treatment from a spiritual advisor about 9.7% of the time in comparison to % from a non-psychiatrist mental health worker and 12% from a psychiatrist. These numbers substantiate the literature's description of religiosity's benefit and are indicative of the perceived level of support that the religious institutions provide. Individual lectures by a multidisciplinary team of experienced clinicians and clergy will include: 1.) The current scope of faith-based mental health initiatives; 2.) Initiatives in rural areas and urban settings; 3.) The challenges and successes related to the development and implementation of such endeavors; and 4.) How 'care for the caregiver' is rendered in this context. This symposium will benefit mental health professionals and clergy who work with populations that have the propensity to seek emotional supports in religious venues.

No. 15A
NO WAYS TIRED: DEVELOPING CARE FOR THE CAREGIVERS

Wilma Kirk-Lee, M.S.W., L.C.S.W., *Licensed Clinical Social Worker, 10707 Braes Bayou Drive, Houston, TX 77071*

SUMMARY:

Following the disasters wrought by Hurricanes Katrina, Rita and Wilma there was an outpouring of support

from first responders, helpers, and counselors from a wide range of non-governmental organizations. Faith institutions were chief among these supportive resources. In light of the individual contributions from clergy and congregational caregivers to counsel disaster-affected people while, in some instances, simultaneously coping with their own losses, there is a need to acknowledge their sacrifices, stress load and exhaustion. This presentation will describe efforts to identify, ameliorate and prevent faith community caregiver burnout.

No. 15B
GATEKEEPER: RURAL CLERGY PITCH-HITTING FOR MENTAL HEALTH IN A RURAL COMMUNITY

Pastor W.S. Lee, M.Div., *10707 Braes Bayou Drive, Houston, TX 77071*

SUMMARY:

Rural Louisiana experienced significant damage and displacement of disaster affected people following Hurricanes Katrina and Rita. Out of necessity, affected citizens turned to faith community resources due to the scarcity of material support and emotional comfort from governmental and other sources. The relative absence of mental health professionals in rural areas pre- and post-disaster placed the faith community in a position of having to meet acute mental health needs. This presentation will discuss the strategies employed by a country pastor to meet the mental health needs of members of his congregation in rural Louisiana.

No. 15C
URBAN NEW ORLEANS AT GROUND ZERO: A BAPTIST CHURCH RESPONDS

Pastor Torin Sanders, *Sixth Baptist Church of New Orleans, 928 Felicity Street, New Orleans, LA 70130*

SUMMARY:

Hurricane Katrina and the floods devastated a large segment of the African American community of New Orleans. Centrality of religious institutions in African American life is a cultural tradition. This presentation will provide an overview of the experience of a Baptist church and its pastor, a social worker, providing emotional and material support to a congregation of people who were directly affected by the disaster. The presenter will characterize the challenges of recognizing overwhelming mental health needs of parishioners and challenging their exclusive reliance on faith-based support. A description of attempts to meet those needs in the cultural context of overwhelming stigma of seeking professional mental health care and a heightened shortage of culturally competent mental health professionals in the New Orleans area after the storm.

No. 15D
EXERCISING FAITH IN MENTAL HEALTH TREATMENT: HELP AND HOPE IN TIMES OF DISASTER

Thelma Ellen, Ph.D., *Psychologist, 7815 Candlegreen, Houston, TX 77071*

SUMMARY:

This presentation will address the ways in which a psychologist infuses spirituality in mental health practice in pre-marital, marital, individual and family counseling for people displaced by disaster.

REFERENCES:

1. National Institute of Mental Health (2005); www.mentalhealth.samsha.gov.
2. Morano CL, King D. Religiosity as a mediator of caregiver well-being: does ethnicity make a difference? J. Gerontol Soc Work, 2005; 45(1-2):69–84.
3. Morano CL, King D. Religiosity as a mediator of caregiver well-being: does ethnicity make a difference? J. Gerontol Soc Work, 2005; 45(1-2):69–84.
4. Zimmerman G, Weber W. Care for the Caregivers: a program for Canadian military chaplains after serving in NATO and United Nations peacekeeping missions in the 1990s. MilMed. 2000 Sep; 5(9):687–90.
5. Gunderson G, Deeply Woven Roots: Improving the Quality of Life in Your Community. Augsburg Fortress Publishers. 1997.
6. Taylor, Chatters and Levin, Religion in the Lives of African Americans: Social, Psychological and Health Perspectives, Thousand Oaks, California, Sage Publications, 2004.
7. Tepper L, et.al. The prevalence of religious coping among persons with persistent mental illness. Psychiatr Serv. 2001 May; 52(5):660–5.

Symposium 16 — **Saturday, October 13 8:30 a.m.-11:30 a.m.**

THE ROLE OF MENTAL HEALTH PROFESSIONALS IN REBUILDING COMMUNITIES: FROM PRACTICE TO POLICY

American Orthopsychiatric Association

Diane J. Willis, Ph.D., *President, American Orthopsychiatric Association; and Professor Emeritus, Depart-*

ment of Pediatrics, Oklahoma University Health Sciences Center, 303 E. Comanche, Norman, OK 73069

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Recognize the mental health impact of disruptions related to disasters, child abuse, incarceration, and suicide/substance abuse upon children and families; and 2.) Describe how mental health professionals can impact and rebuild communities.

OVERALL SUMMARY:

This symposium will focus on re-building communities after a myriad of disruptions in the lives of children and families. Four topics will be discussed including the re-building of communities after a natural disaster, re-building families caught in the criminal or juvenile justice system, re-building of community as a critical ingredient in family support and prevention of mental health problems, and the re-building of communities and related support for Native Americans. A focus will be on mental health issues, effective practice with diverse groups, and policy ideas that practitioners can implement at the local, state, and/or national level.

No. 16A
REBUILDING OF COMMUNITIES DISRUPTED BY NATURAL DISASTERS

Howard J. Osofsky, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Louisiana State University Health Sciences Center, 2020 Gravier Street, New Orleans, LA 70112-2865*

SUMMARY:

Hurricane Katrina resulted in a disaster of proportions not previously known in the United States. The traumatic experiences of children and families during Hurricane Katrina, the flooding that resulted from the breach of the levees, the evacuation, and the aftermath are unprecedented. These topics will be addressed in this presentation.

No. 16B
EXPERIENCES OF CHILDREN AND FAMILIES IN THE AFTERMATH OF HURRICANE KATRINA

Joy Osofsky, Ph.D., *Professor of Pediatrics and Psychiatry, Louisiana State University Health Sciences Center, 2020 Gravier Street, New Orleans, LA 70112*

SUMMARY:

In responding to the enormous mental health needs of children post-Katrina, the Trauma Team of skilled mental health professionals from Louisiana State Univeristy Health Sciences Center (LSUHSC) Department of Psychiatry, provided psychological first aid, crisis intervention, and services. This presentation discusses the work of the LSUHSC Trauma Team, and provides a snapshot of the current mental health status of several thousand children and adolescents returning to Metropolitan New Orleans post-Katrina. Almost one-half of the 4th to 12th grade students and about one-third of younger children (based on parental report) met criteria for mental health services, based on the number and severity of their behavioral symptoms. Children who were separated from their parents or who had experienced previous trauma or loss were most likely to meet criteria. Ongoing risk relates to poverty, slowness of recovery, job loss, and family problems. Knowledge gained from this disaster can aid in understanding and meeting the needs of children and families impacted by disasters, promoting resilience and self-efficacy, and providing evidence-based therapeutic services. Recommendations will be made for the development of a comprehensive national disaster plan for children and families.

No. 16C
FROM ALIENATION TO EFFICACY: BUILDING STRONG COMMUNITIES TO KEEP KIDS SAFE

Gary B. Melton, Ph.D., *Former President, American Orthopsychiatric Association, 158 Poole Ag Center, Clemson, SC 29634-0132*; Robin J. Kimbrough-Melton, J.D.

SUMMARY:

During the past generation, there has been a marked reduction in social capital (the "wealth" in relationships) virtually everywhere in the world. Interpersonal trust, as well as trust in community and national leaders and government institutions, has steadily become weaker. Participation in civic, political, and religious life is increasingly a phenomenon of the past. This increase in social isolation has been accompanied psychologically by increased alienation and boredom, especially among young people. Three other dramatic effects are noteworthy: 1.) The ongoing decline in social capital appears to have resulted in an extraordinary increase in anxiety and depression among children and youth; 2.) At both household and community levels, social capital (independent of social class and ethnicity) is associated with children's safety in their homes; and 3.) Collective efficacy is directly and strongly related to community

safety. Strong Communities, a large foundation initiative in Greenville County, SC, for primary prevention of child abuse and neglect, is powerfully demonstrating ways to disrupt these pernicious trends. Primary data on the nature of community-family relationships, their significance for child safety, and the process of engagement of thousands of volunteers and hundreds of organizations will be presented, with attention to the implications for replication at scale in other communities.

No. 16D
AMERICAN INDIANS THE FORGOTTEN RACE: REBUILDING INDIAN COMMUNITIES

Diane J. Willis, Ph.D., *President, American Orthopsychiatric Association; and Professor Emeritus, Department of Pediatrics, Oklahoma University Health Sciences Center, 303 E. Comanche, Norman, OK 73069*

SUMMARY:

This session provides an overview of the major health/mental health issues facing American Indians with special emphasis on suicide. Strategies for reducing mental health related problems and re-building stronger Native communities and families will be discussed.

REFERENCES:

1. Masten, A. (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56, 227–238.
2. Osofsky, J.D., Osofsky, H.J., & Harris, W.W. (in press). Katrina's Children: Social Policy Considerations for Children in Disasters. Social Policy Reports. Society for Research in Child Development, 2006.
3. Melton GB, Lyons PM Jr: Mental Health Services for Children and Families: Building a System That Works. New York, Guilford, forthcoming.
4. Melton GB, Thompson RA, Small MA (eds): Toward a Child-Centered, Neighborhood-Based Child Protection System. Westport, CT, Praeger, 2002.
5. U.S. Advisory Board on Child Abuse and Neglect: Neighbors Helping Neighbors: A New National Strategy for the Protection of Children. Washington, DC, US Government Printing Office, 2003.
6. Olson, L.M., & Wahab, S. (2006). American Indians and suicide: A neglected area of research. Trauma, Violence, & Abuse, 7(1), 19–33.
7. Willis, D.J., & Subia Bigfoot, D. (2003). On native soil: The forgotten race: American Indians. In Robinson, J.D., & James, L.C. (Eds.) Diversity in Human Interactions: The Tapestry of America. New York: Oxford University Press.
8. Vasquez, D.A., Willis, D.J., & Lipsitt, L.P. (2006). Ethnic disparities in Sudden Infant Death Syndrome: A literature review of their origins. Manuscript submitted.

Symposium 17 **Saturday, October 13 2:00 p.m.-5:00 p.m.**

RESEARCH IN DIVERSE AND UNDERSERVED POPULATIONS IN THE SOUTH: CURRENT REALITIES AND IMPERATIVES FOR THE FUTURE

OMNA on Tour in the Gulf Coast Track

Basil D. Halliday, M.S.C., *President/CEO, Diversed Research, 116 Crutchfield Street, Durham, NC 27704*; Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Discuss historical and contemporary causes for low minority participation in clinical research; and 2.) Identify key strategies for maximizing minority recruitment and retention in research.

OVERALL SUMMARY:

This presentation will provide an overview of the issues underlying the crisis in participation of minorities in research with a special focus on populations in the Southern U.S. The specter of the Tuskegee syphilis experiment still looms in the minds of many people of color as a reason to avoid research participation at all costs. The presenters take advantage of the opportunity to focus on the Deep South and neighboring states to highlight efforts to overcome barriers to research participation. Presenters will offer their experiences in conducting research in minority populations and in participating in clinical trials in the role of a site management and/or contract research organization, physicians in private practice engaging in clinical trials in rural settings, those conducting research in an urban area, ivory tower academic institution, and those who are individual research subjects. Presenters will also offer methods currently employed for successful recruitment and retention and avenues to pursue in the future to maximize minority participation in research.

No. 17A
A PERSPECTIVE OF A CLINICAL TRIALS PARTICIPANT

Darlene Nipper, *Consultant, 1350 Pennsylvania Avenue, N.W., Suite 211, Washington, DC 20004*

SUMMARY:

In this presentation, the presenter will chronicle her experience participating in a breast cancer treatment clinical trial. She will offer approaches and strategies for increasing participation of people of color in clinical trials that revolve around maximizing the inherent trust needed between researcher and participant.

No. 17B
A MISSISSIPPI DOCTOR'S SUCCESS IN CLINICAL RESEARCH

Nate Brown, M.D., *Medical Director, Mid-Delta Family Practice Clinic, 403 S. Davis Street, P.O. Drawer 1040, Cleveland, MS 38732*

SUMMARY:

A home grown cardiologist in the Deep South speaks of his dazzling success in recruiting black patients in his practice to enthusiastically participate in numerous clinical trials. This presenter will reflect on the reasons for his success in recruitment and retention of African American patients in Mississippi.

No. 17C
THE CAPITAL INVESTMENT MODEL OF RECRUITMENT AND RETENTION OF MINORITIES IN CLINICAL RESEARCH

Christopher L. Edwards, Ph.D., *Assistant Professor of Behavioral Sciences; and Assistant Clinical Professor, Duke University's Pain and Palliative Care Center, 932 Morreene Road, Durham, NC 27705*

SUMMARY:

This presentation will focus on the social and environmental context and how it influences or discourages disadvantaged populations from participating in research endeavors. The speaker will offer several strategies and recommendations for researchers to pursue in order to maximize attractiveness and acceptability of participation in research among diverse and disadvantaged populations.

REFERENCES:

1. Nguyen T, Riolo S, Flack C, et.al. Comparative prevalence of depression by race/ethnicity: findings from the Third National Health and Nutrition Examination Survey (NHANES). Program and abstracts of the American Psychiatric Association 2004 Annual Meeting; May 1–6, 2004⅖w York, NY. Abstract NR174.
2. U.S. Department of Health and Human Services. (2001) Mental Health: Culture, race and ethnicity-A supplement to Mental Health: A report of the Surgeon General. Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
3. Recruitment and Enrollment Assessment in Clinical Trials (REACT) project. Control Clinical Trials 1996; 17(1):46–59.
4. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community based research: assessing partnership approaches to improve public health. Annu Rev Public Health. 1998;19:173–202.
5. Khaliq W, Gross M, Thyagarajan B, Jones-Webb R. What motivates minorities to participate in research? Minn Med. 2003 Oct;86(10):39–42.

Symposium 18 **Saturday, October 13 2:00 p.m.-5:00 p.m.**

CHANGING THE WORLD: DEVELOPING INTEGRATED SYSTEMS OF CARE IN NEW ORLEANS AND LOUISIANA

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School; and Senior Systems Consultant, ZiaLogic and ZiaPartners, 100 Powdermill Road, #319, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Define the eight principles of a comprehensive, continuous integrated system of care and their application to system design within an integrated recovery philosophy; 2.) Recognize the twelve steps of implementation for integrated systems and their utilization in real world systems; 3.) Identify real world applications and use of top down, bottom up CQI strategies for building dual diagnosis capability at a system, program, clinical practice, and clinician level; and 4.) Describe the real challenges of implementation in New Orleans and Louisiana, with regards to utilization of quality improvement as a change strategy, and the role of system administrators, program leaders, and clinicians in the process.

OVERALL SUMMARY:

Individuals with co-occurring mental health and substance use disorders represent a population with poorer outcomes and higher costs in multiple domains, presenting with sufficient frequency in all systems and services that it is recognized that "dual diagnosis is an expectation, not an exception." As a result, there has been increasing recognition of the need for developing a systemic approach to serving these individuals. Minkoff

and Cline have developed an implementation process for a model termed Comprehensive Continuous Integrated System of Care, in which within existing resources in any system, all programs can be designed as "dual diagnosis programs" meeting minimal standards of dual diagnosis capability, but each program has a different job, to provide matched services to its existing cohort of cod clients based on a set of consensus best practice principles within an integrated disease and recovery philosophy. In this symposium, the presenters describe the model, and the 12-step implementation process and implementation toolkit, based on strategic planning and continuous quality improvement principles. The remainder of the symposium is dedicated to describing the ongoing process for implementation of system wide changes in the capacity to provide integrated services within the Louisiana Office of Mental Health and Office of Addictive Disorders, under the auspices of the state's Co-occurring Disorder State Infrastructure Grant (COSIG), and the efforts to implement integrated services in this context in the New Orleans Metropolitan Area.

No. 18A
COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE: DESCRIPTION OF THE FRAMEWORK

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School; and Senior Systems Consultant, ZiaLogic and ZiaPartners, 100 Powdermill Road, #319, Acton, MA 01720*

SUMMARY:

Individuals with co-occurring disorders are an expectation, not an exception throughout the service system, associated with poor outcomes and high costs in multiple domains. To provide more welcoming, accessible, integrated, continuous, and comprehensive services in a system of care with scarce resources, the CCISC model organizes a framework for system design in which every program is a dual diagnosis program meeting minimum standards of Dual Diagnosis Capability (DDC) (along with some specialized program elements that are Dual Diagnosis Enhanced) within the context of its existing resources, but each program has a different job, based first on what it is already designed to be doing, and the people with co-occurring disorders already there, but providing matched services based on a set of research derived integrated consensus best practice principles within the context of its existing resources. Similarly, each clinician is a dual diagnosis clinician meeting minimal standards of dual competency regardless of licensure or job description, to provide properly matched services to the clients in his or her caseload. This presentation summarizes the model, the eight principles, and the 12-step program of CCISC implementation involving a strategically planned CQI process that incorporates a "top-down, bottom-up and back again" interactive design, in which the system, programs, clinical practices, and clinician competencies all progress together building on existing system strengths and resources.

No. 18B
CCISC: REAL WORLD APPLICATION AND IMPLEMENTATION STRATEGIES

Christie A. Cline, M.D., M.B.A., *President, Zialogic, 12231 Academy Road, N.E., #301/313, Albuquerque, NM 87111*

SUMMARY:

Based on the author's experience with implementation projects in 30 states and three Canadian provinces during the past five years, this presentation will discuss the specific strategies by which the CCISC framework can be adapted to the needs of real world systems with complex structures and limited resources. Topics will include the design of the quality improvement partnership that incorporates the top down, bottom up feedback loop, common traps regarding data collection, funding and training and how to avoid them, methods for implementing programmatic improvement and clinician comptency development through the creation of an empowered cadre of practice improvement specialists or "change agents", and other concrete techniques. The presentation will also discuss the CCISC toolkit, including system fidelity tool (CO-FIT), program self-assessment for dual diagnosis capability (COMPASS), and clinician self-assessment of attitudes and skills (CODECAT). There will be an emphasis on the fundamental clinical processes of welcoming engagement, integrated relationships, universal integrated screening, integrated longitudinal strength-based assessment, and stage specific assessment and treatment planning, as grounding features of clinical practice development. Finally, examples of application of the model will be discussed in a range of state and county systems across the U.S. and Canada.

No. 18C
LOUISIANA INTEGRATED TREATMENT SERVICES (LITS) INITIATIVE

Tanya McGee, M.S., LAC, *COSIG Project Coordinator, State of Louisiana, Department of Health and Hospitals, 3501 5th Avenue, Suite A, Lake Charles, LA 70607*

SUMMARY:

Historically, the Louisiana Office of Mental Health (OMH) and Office for Addictive Disorders (OAD) typically deliver parallel or sequential services, lacking integration and continuity, and capacities have been insufficient to meet the need of the persons who suffer from co-occurring SA and MH disorders. This has resulted in confusion for those needing service, as well as those providing it. The goal of the LITS Intiative is to develop a treatment delivery system within the state of Louisiana in which all publicly-funded Mental Health and Substance Abuse programs are Co-Occurring Diagnosis Capable (CODC). Focus is to implement a fundamental change in the way the OMH and OAD do business throughout the health care system. The initiative is working towards making access to needed service easier and improving treatment outcomes. The main areas of focus within LITS include the following: 1.) Workforce Development. Over 1900 MH and AD staff across the state received a 1-day Basic Orientation training and a 2-day Advanced Clinical Training. Current workforce development focus is on the development of a COD professional credential. 2.) Program Evaluation. LA adopted the DDCAT and DDCAT-MH Fidelity tools in order to provide a standard measure of COD Capability across the state. Thirty-six DDCAT's will be completed by November 30th and reports generated from the fidelity data will guide local implementation planning and state level sustainability planning. Clinical Protocols. LA has developed and is currently utillizing a standard definition of COD, as well as a statewide welcoming policy. Information Management. LA has developed a shared data warehouse between OMH and OAD data systems. Current focus within IM is on identification and collection of common data elements. Funding. LA is working toward Medicaid reimbursement for specific SA services, projected completion is July 2007. Current funding work is focused on the analysis of OMH and OAD cost expenditures in the area of psychiatric services, medications, and drug screening.

No. 18D
DEVELOPING INTEGRATED SYSTEMS OF CARE IN NEW ORLEANS POST-KATRINA

Jacqueline Smith, L.C.S.W., *Deputy Director, Metropolitan Human Services District, 650 Poydras Street, Suite 2420, New Orleans, LA 70130*

SUMMARY:

The Metropolitan Human Services District (MHSD) has been organized as a private, non-profit entity working in partnership with the State of Louisiana's Offices of Mental Health and Office of Addictive Disorders to provide behavioral health services (mostly adult services) to the residents of New Orleans and surrounding parishes. Prior to Hurricane Katrina, MHSD had a vision of developing an integrated system and had begun participation in the Louisiana COSIG project, but mostly operated in separate mental health, developmental disability and addictive disorder. Following Katrina, there was a need for rapid re-deployment of services in a way that was integrated by necessity, both integrated across the boundaries of mental health, substance abuse, and developmental disability, as well as integrated into primary health care settings. This presentation will provide an overview of the impact of the disaster on the mental health and substance abuse service delivery systems within MHSD. It will address how coordinating a response across those systems led to unexpected opportunities for integration, and how, as the immediate disaster response situation subsided, barriers to continuing to make progress in integration needed to be addressed as a challenge for maintaining a sustainable infrastructure for integrated services.

REFERENCES:

1. Minkoff and Cline, Changing the World: Design and Implementation of Comprehensive Continuous Integrated Systems of Care. Psychiatric Clinics of North America, Dec 2004.
2. Minkoff and Cline, Developing Welcoming Systems of Care for Individuals with Co-occurring Disorders, Journal of Dual Diagnosis, 2005.
3. Curie C, Minkoff K, Hutchins, G, and Cline C, "Strategic Implementation of Systems Change for Individuals with Mental Health and Substance Use Disorders" J. Dual Diagnosis, 1(4):75–95. 2005.
4. McGovern, M: DDCAT: A tool for evaluating dual diagnosis capability.
5. Minkoff, K: Dual Diagnosis Capability: Moving from Concept to Implementation, Journal of Dual Diagnosis, 2006.

Symposium 19 **Saturday, October 13 2:00 p.m.-5:00 p.m.**

HOW TO KEEP YOUR PATIENTS FROM DYING

Medical Directors Council of the National Association of State Mental Health Program Directors

Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; Alan Q. Radke, M.D., M.P.H., *Chief Medical Officer, State Operated Services, Minnesota Department of Human Services, 444 Lafayette Road, North St. Paul, MN 55164-0979*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Discuss actions they can take to reduce excess mortality among persons with severe mental illness; 2.) Recognize that persons with severe mental illness can successfully quit smoking and be familiar with approaches to assist them in inpatient settings; 3.) Identify the difference between a public health approach and treatment approach to addressing suicide; and 4.) Apply the public health approach to suicide prevention in their community.

OVERALL SUMMARY:

The Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) membership includes medical directors from state mental health authorities from across the country. The NASMHPD Medical Directors Council supports state Mental Health Commissioners/Directors by developing evidence-based policy papers addressing key areas of clinical policies for the public mental health system. These technical papers have guided recent policy changes and practices in the public mental health system. This symposium will present the Councils most recent reports: Morbidity and Mortality in Persons with SMI, Smoking Policy and Treatment in State Hospitals, and Suicide Prevention for persons with SMI. The first presentation on excess mortality in persons with severe mental illness covers the causes of the shocking explosion and premature deaths that have occurred in the past ten years. The second and third presentations on smoking in state hospitals, reviews the forces leadings to the ongoing rapid adoption of smoke-free campuses at state hospitals nationwide. The fourth presentation on suicide prevention, points to a new public health approach for the public mental health system in order to reduce the all too common tragedy of suicide.

No. 19A
MORBIDITY AND MORTALITY IN PERSONS WITH SEVERE MENTAL ILLNESS

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mental Health; and Associate Clinical Professor of Psychiatry, Ohio State University, 30 East Broad Street, 8th Floor, Columbus, OH 43266*; Patricia Singer, M.D.

SUMMARY:

People with serious mental illness (SMI) die, on average, 25 years earlier than the general population. State studies document recent increases in death rates over those previously reported. This is a serious public health problem for the people served by our state mental health systems. While suicide and injury account for about 30–40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases. People with serious mental illness also suffer from a high prevalence of modifiable risk factors, in particular obesity and tobacco use. Compounding this problem, people with serious mental illness have poorer access to established monitoring and treatment guidelines for physical health conditions. Among persons with SMI, the ''natural causes'' of death include: Cardiovascular Disease; Diabetes; Respiratory Disease; and Infectious Disease. The rates of mortality from these diseases for the SMI population are several times those of the general population. We recommend actions to address the causes which include modifiable risk factors, access to care, and psychotpic medication.

No. 19B
SURVEY AND COMPARATIVE ANALYSIS OF SMOKING POLICY AND PRACTICES IN STATE HOSPITALS

Joseph J. Parks, M.D., *Medical Director, Missouri Department of Mental Health, 1706 East Elm Street, P.O. Box 687, Jefferson City, MO 65102*; Mary E. Diamond, D.O.

SUMMARY:

In 2006, a survey of 222 state mental health facility's smoking policies and practices was conducted by the NASMHPD Research Institute, Inc. A total of 158 surveys (71%) were returned. 41% of respondents did not permit smoking at their facility, including on grounds. Since 2002, on average, one more SMHA hospital goes smoke-free each month. This trend is likely to continue for the foreseeable future. It took most of these facilities an average of nine months to make the transition from smoking to non-smoking. These respondents cited the improved health of patients, cleaner grounds/environment, and more time for treatments as advantages to becoming a smoke free facility. Interestingly, they found a decrease in behavioral problems related to smoking habits, less violence, and increased staff satisfaction after implementing no smoking policies. While surprising, these outcomes are in fact similar to those found in other facilities that have implemented smoking bans both in the U.S. and abroad. 59% of respondents still allow smoking at their facilities. However, almost half of these facilities (45%) are going tobacco free in the future, most within a year.

No. 19C
SMOKING POLICY AND TREATMENT IN STATE OPERATED PSYCHIATRIC FACILITIES

Peggy H. Jewell, M.D., *Medical Director, Department of Health and Human Services, State of Oklahoma, 1200 N.E. 13th Street, P.O. Box 53277, Oklahoma City, OK 73152*; Mary Ellen Foti, M.D.

SUMMARY:

A preponderance of evidence has clearly established the deleterious health effects of tobacco smoking and second hand or environmental tobacco smoke. In mental health facilities, tobacco smoking leads to negative outcomes for mental health treatment, the treatment milieu, overall wellness and, ultimately, recovery. Smoking promotes coercion and violence in facilities among patients and between patients and staff. It occupies a surprising amount of staff and patient time that could be better used for more productive activities. It is a poor (and often only) substitute for practice in decision-making and relationship building and is inappropriate as a means to manage behavior within the treatment milieu. While smoking can be framed as the one 'choice'consumers get to make while inpatients, and a personal 'choice' for staff, it is critical to realize that addiction is not a choice, but quitting smoking is. Currently, 59% of public mental health facilities allow smoking. The report presented in this segment urges public mental health systems to commit to educating individuals about the effects of tobacco and facilitating and supporting their ability to manage their own physical wellness.

No. 19D
SUICIDE PREVENTION APPROACHES FOR STATE MENTAL HEALTH AND PUBLIC HEALTH AUTHORITIES

Alan Q. Radke, M.D., M.P.H., *Chief Medical Officer, State Operated Services, Minnesota Department of Human Services, 444 Lafayette Road, North St. Paul, MN 55164-0979*; Laura K. Nelson, MD; Elsie J. Freeman, M.D.

SUMMARY:

In 1998, the U.S. Surgeon General, David Satcher, M.D., identified suicide as a major public health problem. This resulted in The Surgeon General's Call to Action to Prevent Suicide (1999) where Dr. Satcher established the promise that, "We must promote public awareness that suicides are preventable. We must enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment, and we must reduce the stigma associated with mental illness that keeps many people from seeking help that could save their lives." The recommendations for mental health and public health authorities in the presented report urge development and implementation of suicide prevention planning in some states that do not currently have a suicide prevention plan. These recommendations provide a roadmap for state mental health authorities to be more culturally competent in the public health model and become more effective and active participants in the public health prevention arena. Providing a common background, overview, and complementary agency specific recommendations to both public health and mental authorities in the same document will promote partnership and collaboration. As public mental health systems follow the roadmap laid out in the report presented in this session more suicides will be prevented.

REFERENCES:

1. Goff, D., Cather, C. et.al. Medical Morbidity and Mortality in Schizophrenia: Guidelines for Psychiatrists, Journal of Clinical Psychiatry, (February 2005) vol 66:2, pp 183–194.
2. Lasser, K.,Wesley B.J., Woolhandler S., Himmenstein, D.U., McCormick D. & Bor, D.H. (2000). Smoking and Mental Illness: A population-based prevalence Study. JAMA 2000:284:2606–2610.
3. Lasser, K.,Wesley B.J., Woolhandler S., Himmenstein, D.U., McCormick D. & Bor, D.H. (2000). Smoking and Mental Illness: A population-based prevalence Study. JAMA 2000:284:2606–2610.
4. Schroeder, S. A. (2005) What to Do With a Patient Who Smokes. JAMA, Vol. 294, No. 4.
5. U.S. Public Health Service, The Surgeon General's Call to Action to Prevent Suicide. Washington, DC: 1999. (www.surgeongeneral.gov/library/calltoaction/calltoaction.htm).

Symposium 20 **Sunday, October 14**
8:30 a.m.-11:30 a.m.

INNOVATIONS IN LEVEL OF CARE ASSESSMENT FOR INDIVIDUALS WITH CO-OCCURRING DISORDER

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School; and Senior Systems Consultant, ZiaLogic and ZiaPartners, 100 Powdermill Road, #319, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1.) Describe the concept of independent de-linked dimensions of service intensity, and identify four such dimensions; 2.) Discuss the concept of

multidimensional service intensity assessment, and identify six assessment dimensions commonly utilized for addiction and/or psychiatric patients; and 3.) Evaluate the current utility and validity of the ASAM PPC 2R and LOCUS 2.0 in application to real clinical situations for individuals with co-occurring disorders.

OVERALL SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care, there has been surprisingly little available objective data on the clinical process of utilization management and level of care determination. Fortunately, in recent years, this has begun to change, as there has been increasing development and investigation of more sophisticated instruments for assessment of level of care or service intensity requirements for individuals with mental health and/or substance use disorders. This symposium attempts to bring together in a single forum a presentation of the most up to date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment. The symposium continues with presentations by the major developers of the most well known service intensity assessment tools for individuals with mental health and substance disorders: The ASAM Patient Placement Criteria, Second Edition Revised (2001), and the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2.0) (2001). Each instrument will be described by its major author, along with information on validity and reliability studies, and instructions on use. The final section of the symposium will emphasize audience participation in the level of care assessment process. A sample case illustrating a complex patient with co-occurring disorders in crisis will be distributed, along with copies of the tools, and the audience will participate in using each tool to evaluate level of care. The strengths and limitations of each instrument will then be discussed. In total, the symposium will present the participant with an accurate portrayal of the current field of level of care assessment, and the directions for future research. This material will be valuable for anyone – clinician or manager involved in the development of managed care evaluation systems, or in the delivery of clinical services that require such utilization management or assessment.

No. 20A
PRINCIPLES OF UTILIZATION MANAGEMENT AND LEVEL OF CARE ASSESSMENT

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School; and Senior Systems Consultant, ZiaLogic and ZiaPartners, 100 Powdermill Road, #319, Acton, MA 01720*

SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case management intensity, which lead in turn to the reconceptualization of "levels of care" as "matrices of service intensity". In this model, the independent dimensions are "de-linked" so that program models can vary flexibly across dimensional categories. The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connecting ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in this symposium will illustrate how this is currently being done for individuals with substance and/or psychiatric disorders (ASAM PPC 2R, LOCUS 2.0). The goal of the presentation will be to provide a general framework for attendees to consider utilization management as a CLINICAL decision making process, and to be able to objectively evaluate current methodology for objective service intensity assessment and decision making.

No. 20B
UNDERSTANDING AND USING THE PATIENT PLACEMENT CRITERIA OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

David Mee-Lee, M.D., *Chair, Coalition for National Clinical Criteria, 4228 Boxelder Place, Davis, CA 95616*

SUMMARY:

Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans and level of care placement. The Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. The Revised Second Edition (ASAM PPC-2R) published in April 2001, added criteria for co-occurring mental and substance-related disorders, which made the ASAM PPC-2R even more applicable to behavioral health systems. Participants will: 1.) Review the underlying principles of the ASAM Patient Placement Criteria (PPC); 2.) Identify how recent revisions can assist mental health systems improve care for "dual diagnosis" patients; and 3.) Understand how to use the criteria in clinical practice.

No. 20C
LOCUS: A SIMPLE METHOD FOR LEVEL OF CARE DECISIONS

Wesley E. Sowers, M.D., *President, American Association of Community Psychiatrists; Member, APA/IPS Scientific Program Committee; and Medical Director, Human Services, Allegheny County, 304 Wood Street, Room 505, Pittsburgh, PA 15222*

SUMMARY:

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) was developed by the American Association of Community Psychiatrists and has been in use over the past ten years in various parts of the U.S. and abroad. It evaluates recipients of behavioral health services along six dimensions and defines six levels of resource intensity. It guides decisions regarding the matching of needs and services in a manner that strikes a balance between quality care and the wise use of resources. It is designed to be easily understood by both service users and providers and to facilitate a collaborative approach to needs assessment and service planning. It provides a methodology to facilitate rapid and consistent level of care recommendations that are not overly burdensome for the clinician.

This section will describe the circumstances leading the creation of LOCUS and the principles used to guide its development. It will provide an overview of the instrument and how it is used. An overview of reliability and validity testing will also be provided. A sample assessment will be completed with participants using a clinical vignette.

REFERENCES:

1. Minkoff and Regner: Innovations in Dual Diagnosis Treatment in Managed Care: The Choate Dual Diagnosis Case Rate Program: J. Psychoactive Drugs, 1999.
2. Minkoff: Level of Care Determination for Individuals with Co-Occurring Disorders: Psychiatric Rehabilitation Skills: 2001.
3. Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
4. Mee-Lee, David (2001): ''Treatment Planning for Dual Disorders''. Psychiatric Rehabilitation Skills Vol. 5, No.1, 52–79.
5. Sowers WE, George C, Thompson KS; Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS): A Preliminary Assessment of Reliability and Validity, Community Mental Health Journal, Vol. 35, No 6, December 1999.

Workshop 1 — Thursday, October 11, 10:00 a.m.-11:30 a.m.

MANAGING VIOLENCE IN THE TREATMENT SETTING

Jeff Lucey, M.D., *Director of Residency Training, Department of Psychiatry, Mount Sinai School of Medicine, Cabrini Medical Center, 227 East 19th Street, New York, NY 10003*; Madeleine S. Abrams, L.C.S.W.; Joseph Battaglia, M.D.; Daniel J. Smuckler, M.D.; Lindsey D. Rutledge, M.D.; Ann Baron, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Understand the causes of violence; 2.) Recognize danger and ways to minimize risk; 3.) Demonstrate ways to manage situations in which violence occurs; and 4.) Learn skills that will effectively deal with the emotional impact of violence on residents.

SUMMARY:

Anyone working or training in a psychiatric center is likely to encounter violence either as a witness, a participant in managing the consequences of a violent incident, or as a victim. The enhancement of training and discussion about the issue of violence in psychiatric populations would be beneficial for clinical settings and training sites. In this workshop, we will review the various causes of violence in clinical settings and propose a model for safety competency. We will consider ways in which staff and students can be taught to recognize danger, prevent and minimize the risk of violence, deescalate threatening situations, and handle those violent situations that are unavoidable. Special emphasis will be placed on coping with the emotional sequelae surrounding violence and the important role of supervisory intervention. Role plays, videotapes, and personal and professional anecdotes and experiences will be included. We hope to open a dialogue with workshop participants about this very important clinical issue.

REFERENCES:

1. Raja M, Azzoni A: Hostility and Violence of Acute Psychiatric Inpatients. Clinical Practice and Epidemiology in Mental Health, 2005, pp. 1–11.
2. Fazel S, Crann M: The Population Impact of Severe Mental Illness on Violent Crime. American Journal of Psychiatry 3: 1397–1403

Workshop 2 — Thursday, October 11, 10:00 a.m.-11:30 a.m.

FRONT-LINE STAFF: COUNTERTRANSFERENCE AND RECOVERY

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York; and Associate Clinical Professor, Department of Psychiatry, Columbia University College of Physicians & Surgeons, 1250 Broadway, 22nd Floor, New York, NY 10001*; Neil Pessin, Ph.D.; MacDara O'Sullivan

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize different types of countertranference occurring in front-line mental health workers providing specialized, community-based services for people with serious and persistent mental illness.

SUMMARY:

Although it is commonly believed that the treatment relationship is central to recovery, there is not much literature on the experience of front-line mental health workers providing community-based services for the seriously and persistently mentally ill. These workers, often case managers with relatively little clinical training, must relate to the system's most complicated clients. Such clients are often managed in special programs, like assertive community treatment (ACT) and intensive case management (ICM), because of their histories of severe illness, treatment non-compliance, substance abuse, and the many psychosocial problems related to poverty. Workers must see their clients frequently, for lengthy visits, and in community settings which do not provide the usual boundaries found in the office or clinic. Powerful countertransference reactions are inevitable, ubiquitous, and can bear directly on client outcomes. We conducted focus groups with ACT, ICM, and other case managers of the Visiting Nurse Service of New York's Community Mental Health Services to learn more about their experience and countertransference. This workshop will present data from these groups; presenters will include case managers who were group participants. We will encourage participants to share their own experiences and thoughts about countertransference and recovery.

REFERENCES:

1. Kirsch B, Tate E: Developing a comprehensive understanding of the working alliance in community mental health. Qualitative Health Research :1054–1074, 2006.
2. Borg MB, Garrod E, Dalla M: Intersecting "real worlds": community psychology and psychoanalysis. The Community Psychologist 34:-19, 2001.

Workshop 3 — Thursday, October 11, 10:00 a.m.-11:30 a.m.

POTENTIAL IMPACT OF THE RECOVERY MODEL ON DSM-V

Roger Peele, M.D., *Chief Psychiatrist, Montgomery County Department of Health and Human Services, 401*

Hungerford Drive, Rockville, MD 20849; Maryam A. Razavi, M.D.; Samantha A. Shlakman, M.D.; Sheela Kadalar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe some of the potential impacts of the Recovery Model on DSM-V.

SUMMARY:

One of the major new developments since the development of DSM-IV is the Recovery Model with its emphasis on diagnosis that considers personally relevant goals and focuses on improving natural supports. Can DSM-V's [due in about 2011] criteria sets allow for personally relevant goals? Will there be any room in DSM-V's criteria set for the need for natural supports? Can a diagnostic system include goals of meaningful relationships and satisfying work? These issues will be presented briefly to stimulate discussion among the workshop attendees.

REFERENCES:

1. Glynn SM, Cohen AN, Dixno LB, Niv N: The potential impact of the recovery movement on family interventions for schizophrenia: opportunities and obstacles. Schizophr Bull, 2006 Jul; 32(3):451–63.
2. Addington J, Collins A, McCleery A, Addington D: The role of family work in early psychosis. Schizophr Res. 2005 Nov 1; 79(1):77–83.

Workshop 4 **Thursday, October 11 10:00 a.m.-11:30 a.m.**

POST-PSYCHOTIC ADJUSTMENT: THE MAPP RECOVERY PROGRAM

Mary Moller, M.S.N., D.N.P., *Doctor of Nursing Practice, and Advanced Registered Nurse Practitioner, Suncrest Wellness Center, 9103 N. Division Street, Lower Level, Spokane, WA 99218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Discuss the cognitive processes of adjustment to having a psychotic episode and being diagnosed with schizophrenia; and 2.) Diagnose achievement of clinical milestones of post-psychotic adjustment.

SUMMARY:

The Milestones of Adjustment Post-Psychosis (MAPP) Recovery Model is based on a phenomenological study of nine participants with schizophrenia, ages 21–37 enrolled in a first-episode psychosis (FEP) treatment program. A dynamic, four-phase process from cognitive dissonance to insight, followed by achievement of cognitive constancy culminating in a return to ordinariness emerged as a conceptual model. Fifty-seven emotional, interpersonal, cognitive, physiological, and spiritual themes were identified. Emphasis was placed on the post-psychotic processes of discerning the reality of others from the unreality of self, establishing and maintaining cognitive stability, and moving forward. A 3–5 year post- FEP trajectory was identified. Achieving pharmacological efficacy to consistently diminish symptoms took 6–12 months. An additional 6–18 months was required to master the process of autonomously conducting reliable reality checks. This skill signaled the beginning of insight and was dependent on medication efficacy and ongoing support. Once insight was attained, milestones of cognitive constancy included resuming normal interpersonal relationships and mustering the internal grit to consider re-engaging in age-appropriate activities. This phase lasted one to three years. Four participants had entered the final phase of ordinariness. Treatment implications of the MAPP trajectory, absence of cognitive ability to have insight, inability to achieve reality reorientation skills, and the capacity to move toward ordinariness are discussed.

REFERENCES:

1. Carpenter WT: Targeting schizophrenia research to patient outcomes. The American Journal of Psychiatry 2006; 3: 353–356.
2. Fekete DJ: How I quit being a "mental patient" and became a whole person with a neurochemical imbalance: Conceptual and functional recovery from a psychotic episode. Psychiatric Rehabilitation Journal 2004; 28: 189–194.

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

OMNA ON TOUR IN THE GULF COAST: APA MAKING AN IMPACT ON DIVERSITY, DISPARITIES, AND CULTURAL COMPETENCE

OMNA on Tour in the Gulf Coast Track

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Carolyn B. Robinowitz, M.D.; Altha J. Stewart, M.D.; Francis G. Lu, M.D.; Stephen A. McLeod-Bryant, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Recognize how the APA is addressing diversity in mental health care and in the profession of psychiatry; and 2.) Understand the cause of, and

strategies for, eliminating disparities in mental health care in minority and underserved populations.

SUMMARY:

As declared in the Surgeon General's Report on Mental Health: Culture, Race and Ethnicity, "...the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily though the lenses of racial and cultural diversity, age, and gender." APA is committed to eliminating racial and ethnic disparities in mental health care and doing so is a top priority. This workshop will examine APA's policies, strategies and structures that address disparities in mental health care and cultural competency in psychiatry. Particular attention will be given to APA's Action Plan to Reduce Mental Health Disparities for Racial and Ethnic Minorities and to the Office of Minority and National Affairs' public education program, OMNA on Tour, which engages local communities in discussions about problems resulting from mental health care inequities and strategies for eradicating them at the local level. This workshop will also touch on various dimensions of disparities in the context of minority and underserved populations affected by the Gulf Coast hurricanes and thus set the stage for subsequent presentations that are part of this conference's special track, OMNA on Tour in the Gulf Coast: Eliminating Mental Health Disparities in Diverse and Underserved Populations.

REFERENCES:

1. U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
2. Smedley B, Stith A, Nelson A (eds); Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy, Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC, National Academies Press, 2002.

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

ADDRESSING SOMATIC ILLNESS ON AN ACT TEAM: ANOTHER PART OF RECOVERY

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify issues around somatic problems and the provision of medical care for people receiving ACT services; and implement strategies for ensuring provision of appropriate somatic care for this population.

SUMMARY:

There is substantial literature indicating that people with severe mental illness (SMI) experience more medical problems than the general population with consequences including shortened life expectancy and reduced quality of life. People with SMI also experience significant barriers to medical care. At the University of Maryland's urban Baltimore Assertive Community Treatment (ACT) team, in addition to treating psychiatric illness, we have been addressing consumers' acute and chronic somatic needs for years. Common medical issues include diabetes, COPD, hypertension and obesity; 1/3 of consumers are positive for hepatitis B or C, 10% for HIV. Over 80% are cigarette smokers and more than 50% have other substance use disorders. The burden of medical comorbidity in these individuals requires adaptation and innovation by an ACT psychiatrist and treatment team. Approaches include the following: screening and preventive care, education to patients and families regarding medical issues and to somatic providers regarding psychiatric illness and patient needs, sometimes aggressive advocacy for appropriate medical care, creative strategies to breeching barriers to medical care, and occasionally provision of primary care services by the ACT psychiatrist. We will briefly review literature, describe our approach, and with the audience, consider somatic care for people served by an ACT team.

REFERENCES:

1. Daumit GL, Crum RM, Guallar E, Ford DE (2002) Receipt of preventive medical services at psychiatric visits by patients with severe mental illness. Psychiatric Services 53:884–887.
2. Druss BG & Rosenheck RA (1998) Mental disorders and access to medical care in the United States. American Journal of Psychiatry. 155:1775–7.

Workshop 7 **Thursday, October 11**
1:30 p.m.-3:00 p.m.

RECOVERY AND RESILIENCY IN CHILDREN: COMPARISON OF SERVICES AFTER 9/11 AND KATRINA

OMNA on Tour in the Gulf Coast Track

Tatiana A. Falcone, M.D., *Former APA/Bristol-Myers Squibb Fellow; and Child and Adolescent Psychiatry*

Fellow, Cleveland Clinic, 1310 Forest Hills Boulevard, Cleveland, OH 44118; Christina V. Mangurian, M.D.; Yvette Drake-McLin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to: 1.) Identify psychiatric illness in children after disasters; 2.) Understand services provided for children after 9/11 and Katrina; and 3.) Identify helpful interventions to promote recovery and resiliency for children in the event of a disaster in their community.

SUMMARY:

In the last five years the world has been impacted by multiple disasters (9/11- Hurricane Katrina – Hurricane Rita - the Asian Tsunami – the Pakistan Earthquake). Compared to adults where the prevalence of psychiatric illness after disasters increases by 17%, more than 35% of children exposed to a disaster will develop serious mental health problems, such as Post-Traumatic Stress Disorder. After our previous IPS workshop that compared adult mental health service provision after 9/11 and Katrina, there were an overwhelming number of questions regarding the impact of disasters on children and adolescents. In this workshop, we will review how these disasters impacted the mental health of children within these communities. The development and implementation of mental health services for children after 9/11 and Hurricane Katrina will also be reviewed. In addition, we will compare and contrast these traumatic events to determine which aspects of disaster mental health services were universal, which were site specific, and why these differences existed. We will also focus on the efforts to enhance recovery and resiliency in children and adolescents after these disasters. The importance of the early interventions in services for children will be emphasized.

REFERENCES:

1. Covell NH, Allen G, Essock SM, Pease EA, Felton CJ, Lanzara CB, Donahue SA. Service utilization and event reaction patterns among children who received Project Liberty counseling services. Psychiatric Services. 2006. 57(9):1277–82.
2. Gaffney DA. The aftermath of disaster: Children in crisis. Journal of Clinical Psychology. 2006. 62(8): 1001–1010.

Workshop 8 **Thursday, October 11 1:30 p.m.-3:00 p.m.**

DEPRESSION IN PRIMARY CARE: EFFECTIVE IMPLEMENTATION STRATEGIES

Michael A. Trangle, M.D., *Associate Medical Director, HealthPartners Medical Group, 2621 Abbey Hill Drive, Hopkins, MN 55305-2333*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will learn first hand the specific tactics members of the depression collaborative have taken to successfully develop their respective depression programs.

SUMMARY:

This presentation will focus on best practices of how to engage primary care groups, hold them accountable, and adequately support them in improving care for their depressed patients. Optimal and practical roles, structures, and processes between mental health clinicians and primary care teams will be discussed. Issues addressed will include the balancing of face to face collaborative meetings, phone calls, measurement submissions, utilization of outside speakers, intra- and inter-clinic teamwork, and referrals/communication/integration with mental health providers. Specific obstacles to be discussed include: appropriately screening, diagnosing and documenting for depressed patients, dealing with stigma/discomfort, billing issues, roles/work flow issues within primary care clinics, clinical best practices, issues around reliable follow-up, and measurement issues. This workshop will detail the journey of one large (600 physician) multi-specialty group and juxtapose this with progress of the ''action group's'' 12 clinics. This will highlight the role of pilot projects and spread. The presenters will share the modifications required depending on size, complexity, location (rural, suburban, urban), and type of medical record of the primary care clinic. The spectrum of integration models, (including risks, benefits, costs) will be discussed. The genesis and update progress on a state-wide initiative where all the major health plans (including Minnesota- Medicaid) have agreed to pay for a collaborative care model involving primary care and psychiatry, will also be addressed.

REFERENCES:

1. Major Depression in Adults in Primary Care Guideline, Institute for Clinical Systems Improvement, 2006.
2. Follow-Up and Follow-Through of Depressed Patients in Primary Care: The Critical Missing Components of Quality Care, JABFP, November-December 2005, Vol. 18 No.6, Leif Solberg, M.D., Michael Trangle, MD, Arthur Wineman, M.D.

Workshop 9 **Thursday, October 11 1:30 p.m.-3:00 p.m.**

INTERNATIONAL PERSPECTIVES ON AFTERMATH PSYCHIATRY

Kenneth S. Thompson, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, University of*

Pittsburgh, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213; George Witte, M.D.; Alan Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define the role of social and community psychiatry in the aftermath of significant social change.

SUMMARY:

The events of 9/11 and the hurricanes on the Gulf Coast have focused american psychiatry on immediate disaster response. But its clear from these events that the psychiatric impact is much broader and deeper then what occurs in the immediate moment. It may be better to begin to think of the ''psychiatry of aftermath'' as the psychiatry that deals not only with the impact of the trauma, but delves much deeper into how people and communities remake themselves. This workshop will explore the role of psychiatry in the aftermath of three significant, but very divergent social events: The closure of longstay psychiatric hospitals in the Netherlands; The near elimination of aborigines in Australia; and The de-industrialization of America. In addition to addressing the role of psychiatrists in helping individuals, the engagement of the profession with society will be examined. The key role it plays in symbolically attending to the irrationality and distress such events contain within them will be explored.

REFERENCES:

1. The Architecture of Aftermath; Terry Smith University of Chicago 2006.
2. Everything in Its Path; Kai Erickson, Simon and Schuster 1976.

Workshop 10 **Thursday, October 11 1:30 p.m.-3:00 p.m.**

CHALLENGES IN MEETING THE MENTAL HEALTH NEEDS OF PEOPLE DISPLACED OUT OF STATE

OMNA on Tour in the Gulf Coast Track

Larry Hayes, L.C.S.W., *4984 Ozment Ridge Court, Lithonia, GA 30038*; Iman O. Hypolite, M.D., *4413 9th Street, N.W., Washington, DC 20011-7105*; Eugene Lee, M.D.; Sandra A. Maass-Robinson, M.D.; Derek H. Suite, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Demonstrate how some states that received persons displaced by the Gulf hurricanes facilitated their psychiatric needs; and 2.) Recognize the importance of culture in one's adaptation to stressful conditions.

SUMMARY:

This workshop will examine how non-Gulf states responded to the influx of persons displaced by the Gulf Coast Hurricanes. The session will also compare and contrast the experiences of low-income persons relocated to new environments versus their middle-class counterparts. This comparison will have special emphasis on the role of culture in psychosocial adaptation to relocation under traumatic and stressful circumstances.

REFERENCES:

1. Community Response to Disaster. Special Issue; Psychiatric Annals; Feb. 1999; 29(2).
2. Fothergill, A., Darlington J.D., and Maestas, E.G.M. Race, Ethnicity and Disasters in the United States: A Review of the Literature, Disasters, 1999, 23(2): 156–173.

Workshop 11 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

ROOT SHOCK: UNDERSTANDING THE IMPACT OF DISASTER AND DISPLACEMENT IN THE GULF COAST STATES

OMNA on Tour in the Gulf Coast Track

Cheryl Y. Salary, M.D., *183 Birch Court, Pittsburgh, PA 15237-2603*; Mindy J. Fullilove, M.D.; Cheryll Bowers-Stephens, M.D., M.B.A.; Elizabeth C. Henderson, M.D.; Jacqueline M. Feldman, M.D.; Rahn Bailey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Describe the effects of Hurricane Katrina on communities; 2.) Identify psychiatric outcomes of exposure to disaster and displacement; 3.) Recognize the need for networking strategies for health care delivery in response to natural disasters; and 4.) Conceptualize plans for preventive strategies in the event of natural disaster for community health care.

SUMMARY:

Hurricane Katrina is considered one of the worst natural disasters to affect the United States. Hurricanes Katrina and Rita displaced thousands from their homes, jobs and communities. Many in the Gulf faced large personal and property losses. It will take many years to recover from the losses. These losses have highlighted the need for preparedness to mitigate the psychosocial impact of natural disasters. Community rebuilding will require recovery and treatment interventions. Preventa-

tive strategies and community networks will be necessary to provide infrastructure for current and future health care delivery needs for psychiatric and primary care treatment.

REFERENCES:

1. Survey of Hurricane Katrina Evacuees: The Washington Post/ Kaiser Family Foundation/ Harvard University, Henry J Kaiser Family Foundation, September 2005.
2. Ursano, RJ, Fullerton, CS, Norwood, AE (Eds): Terrorism and Disaster: Individual and Community Mental Health Interventions, Cambridge UK, Cambridge University Press, 2003.

Workshop 12 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

MOBILE CRISIS: A DAY IN THE LIFE

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York; and Associate Clinical Professor, Department of Psychiatry, Columbia University College of Physicians & Surgeons, 1250 Broadway, 22nd Floor, New York, NY 10001*; Neil Pessin, Ph.D.; Deirdre' DeLeo-Kiernan, M.A., L.M.S.W.; Leila B. Laitman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize some of the important issues, on both micro and macro levels, affecting mental health workers involved in providing mobile crisis services.

SUMMARY:

Although mobile crisis teams are widely regarded as essential psychiatric services, they have received relatively little empirical study or professional attention. For example, there are no professional organizations or scholarly journals devoted exclusively to mobile crisis services or issues. Beyond a few studies of efficacy, the scant mobile crisis literature mainly contains program descriptions. Despite the stressful and sometimes frightening nature of the work, there has been little examination of the experience of mobile crisis team members. With funding from New York City's Department of Health and Mental Hygiene, the Visiting Nurse Service of New York (VNS) has operated three mobile crisis teams in New York City since 1986. We conducted a series of focus groups with VNS mobile crisis staff to better understand their perspectives about the work, including its mission and effectiveness, realities of a typical day, safety issues, supervisory experience, team dynamics, and degree of support. Focus groups were led by a sociologist/anthropologist with whom we are collaborating. This workshop will present findings from the focus groups, which we hope will stimulate a lively discussion with workshop participants regarding the real life experience of doing mobile crisis work.

REFERENCES:

1. Brown JF: Psychiatric emergency services: a review of the literature and a proposed research agenda. Psych Q 76:139-5, 2005.
2. Cameron KS: Effective ness as paradox: consensus and conflict in conceptions of organizational effectiveness. Management Sci 32:539–553, 1986.

Workshop 13 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

THE CONSUMER-PROVIDER DIALOGUE: A TRANSFORMATION TOOL

American Association of Community Psychiatrists

Wesley E. Sowers, M.D., *President, American Association of Community Psychiatrists; Member, APA/IPS Scientific Program Committee; and Medical Director, Human Services, Allegheny County, 304 Wood Street, Room 505, Pittsburgh, PA 15222*; Sarah Goldstein, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of how consumer-provider dialogues can be useful tools in transformation to recovery-focused behavioral health care.

SUMMARY:

The Consumer-Provider Collaborative of the Allegheny County Coalition for Recovery (Pittsburgh, PA) has been organizing dialogues between comsumers and providers in the region since 1998, and has produced over 20 of these events in various formats over this period. The dialogue is a facilitated discussion between consumers and providers, outside their usual roles, and they are designed to promote mutual respect, understanding and trust by allowing honest and open discussion of one another's individual experiences with the systems of care they are involved with. The dialogue focuses on their respective roles and most importantly, their relationships with each other. Establishing trusting, empathic, and mutually satisfying relationships is one of the cornerstones for developing collaborative partnerships essential in the transformation to person centered recovery oriented services. The dialogue has been a valuable tool for bridging the cultural gap between traditional and recovery oriented services. In this workshop, the dialogue process will be described, as well as the basic principles for planning a dialogue. Time will be reserved

for discussion related to the nature of the dialogue and the planning process.

REFERENCES:

1. SAMHSA, Participatory Dialogues, Washington, DC, 2000.
2. Sowers, WE; Transforming Systems of Care: The AACP Guidelines for Recovery Oriented Services, Community Mental Health Journal, Vol 41 No 6, December 2005.

Workshop 14 **Thursday, October 11 3:30 p.m.-5:00 p.m.**

WHEN THE LEVEES BROKE: A SPIKE LEE DOCUMENTARY

OMNA on Tour in the Gulf Coast Track

Francis G. Lu, M.D., *Chairperson, APA Council on Minority Mental Health Disparities, 143 Galewood Circle, San Francisco, CA 94131*; Johanna F. Paulino-Wooldrige, M.D.; Rochelle Head-Dunham, M.D.; Larry Hayes, L.C.S.W.; Elliott Hill, L.C.S.W., BCD

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the psychiatric dimensions of disasters, such as those experienced by the victims and survivors of Hurricane Katrina; and identify coping strategies that were most helpful to affected people facing disaster.

SUMMARY:

When the Levees Broke: A Requiem in Four Acts, is a 2006 film by director Spike Lee. In four-episodes, the film traces through personal stories the destruction of New Orleans by Hurricane Katrina in 2005, the despair and resilience of the people, and their struggles to rebuild their communities and lives. (Only one episode will be shown in this workshop). ''New Orleans is fighting for its life,'' says Lee. ''These are not people who will disappear quietly - they're accustomed to hardship and slights, and they'll fight for New Orleans. This film showcases the struggle for New Orleans by focusing on the profound loss, as well as the indomitable spirit of New Orleanians.'' Three months after Katrina struck, Lee, cameraman Cliff Charles, and a small crew made eight trips to New Orleans. ''Spike wanted to offer multiple points of view,'' says editor, Sam Pollard. ''He needed to represent the voices from the community, the different levels of government, activists and the celebrity element to provide a balanced take on the issues facing New Orleans.'' Lee and his team selected close to 100 people from diverse backgrounds that represented a wide range of opinions to interview.

REFERENCES:

1. Brinkley D: The Great Deluge: Hurricane Katrina, New Orleans, and the Mississippi Gulf Coast. William Morrow, New York, 2006.
2. Dyson M: Come Hell or High Water: Hurricane Katrina and the Color of Disaster. Cambridge, MA, Perseus Books, 2006.

Workshop 15 **Friday, October 12 8:00 a.m.-9:30 a.m.**

MENTAL HEALTH RESILIENCY AND VULNERABILITY AMONG GAY, LESBIAN, AND TRANSGENDER POPULATIONS

OMNA on Tour in the Gulf Coast Track

Mark H. Townsend, M.D., *Professor of Psychiatry, Louisiana State University Health Sciences Center at New Orleans, 3450 Chestnut Street, Third Floor, New Orleans, LA 70115*; Robert P. Cabaj, M.D.; Terry Mayers, M.Ed., L.C.S.W.; Liz Simon, M.S.W., L.C.S.W

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss several current topics in the treatment of lesbian, gay, bisexual, and transgender individuals.

SUMMARY:

Hurricane Katrina has brought national attention to health disparities among specific populations within the United States. In this panel, we will examine current issues in the mental health treatment of gay male, lesbian, bisexual, and transgender (GLBT) individuals. Our panelists will discuss the profoundly negative effect of methamphetamine use on the health of gay and bisexual men; the mental health needs of older LGBT people whose adaptive skills and social networks were disrupted by the storm; LGBT-specific issues in psychiatric disaster response; and ongoing challenges in establishing and maintaining LGBT-specific institutions.

REFERENCES:

1. Methamphetamine use in urban gay and bisexual populations. Top HIV Med. 2006 14(2):84–7.
2. Prejudice, social stress, and mental health in lesbian, gay, and biseuxal populations: conceptual issues and research evidence. Psychol Bull. 2003 129(5):674–97.

Workshop 16

Friday, October 12
8:00 a.m.-9:30 a.m.

INTREGRATING SYSTEMS THEORY WITH CULTURAL SENSITIVITY IN TREATMENT AND RECOVERY

Madeleine S. Abrams, L.C.S.W., *Director of Family Studies, Albert Einstein College of Medicine, 1500 Waters Place, Bronx, NY 10461*; Jeff Lucey, M.D.; Adi Loebl, M.D.; Makeda N. Jones, M.D.; David A. Stern, M.D.; Adriana E. Shuster, M.D.; Joseph Battaglia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Recognize an approach to incorporating cultural awareness and systems-based learning into the experience of mental health professionals and students; and 2.) Use materials received and implement suggestions for training and treatment.

SUMMARY:

Mental health professionals, psychiatry residents, and consumers come from ethnically, racially, economically, and educationally diverse backgrounds. The ability to integrate one's own experience with the life experience of another, whether similar or different, is essential to becoming an effective clinician. Consumers and families become isolated by stigma, shame, and lack of education and power. Research has shown that an important aspect of recovery is reconnecting consumers with family and social networks. The more insight the treatment team has into these issues, the more effective they will be in engaging and mobilizing community resources. In this workshop, we will discuss ways in which we incorporate biopsychosocial context in treatment, working from the individual to the family to the system. Using film, literature, experiential exercises, personal genograms, home visits, trips to the community, and grand rounds, we will demonstrate how we emphasize not only thinking about culture and systems, but also how clinical team members are challenged to develop a deeper understanding of themselves, the consumers, families, and communities they serve, the culture of the training institutions, and the health care delivery system.

REFERENCES:

1. Reaching Out in Family Therapy-Home-Based, School, and Community Interventions, Nancy Boyd-Franklin and Brenna Hafer Bry, Guilford Press, NY, 2000.
2. Revisioning Family Therapy-Race, Culture, and Gender in Clinical Practice, ed. Monica McGoldrick, Guilford Press, NY, 1998.

Workshop 17

Friday, October 12
10:00 a.m.-11:30 a.m.

OPERATION GUMBO: MIXING STRATEGIES TO FOSTER RESILIENCE IN YOUTH AFFECTED BY DISASTER

OMNA on Tour in the Gulf Coast Track

Toi B. Harris, M.D., *Assistant Professor of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030*; Sherri M. Simpson, M.D.; Kathy Scott-Gurnell, M.D.; Charlotte N. Hutton, M.D.; Martin Woodard, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a broader understanding of how traditional and non-traditional strategies can be employed with children and adolescents to mitigate the negative impact of disaster; and identify opportunities to incorporate novel therapeutic outlets that are culturally competent within the context of mental health services.

SUMMARY:

Children who suffer traumatic experiences can manifest a variety of psychiatric symptoms including depression, anxiety, restlessness, agitation, behavioral changes, and at times features of dissociation. Some children are more at risk or vulnerable to traumatic experiences for unclear reasons. A multidisciplinary team of mental health professionals will review the literature in conjunction with their clinical expertise in school, clinic, religious and community mental health venues in relation to the treatment of childhood trauma. Engaging in the creative process irrespective of treatment locale helps children find inner strengths that help them function and cope with the experiences of everyday living and traumatic experiences. Helping Through Art!, Outreach, and other programs were created to help children define inner, emotional difficulties surrounding the effects of Hurricane Katrina. It is the belief that the creative process involved in making art is healing and life-enhancing.

REFERENCES:

1. Scheeringa MS, Wright MJ, Hunt JP, Zeanah, CH. Factors affecting the diagnosis and prediction of PTSD symptomatology in children and adolescents. Am J Psychiatry (2006). Apr; 3(4):644–51.
2. Bush, J. & Dunn, P. (1992). Art therapy has healing power: Art activities help students through the storm. SunTimes FDLRS- South 14 (1), 10–11.

Workshop 18 **Friday, October 12**
10:00 a.m.-11:30 a.m.

CONFRONTING ISSUES IN SERVICES TO MILITARY POPULATIONS: NATIONAL GUARD, ACTIVE MILITARY, SOLDIERS OF COLOR, AND SERVICE DURING IRAQ

OMNA on Tour in the Gulf Coast Track

Sheron Finister, Ph.D., *P.O. Box 23, Garden City, LA 70540*; Falu Rami, M.A.; Sandra Williams-Ortega, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Describe the National Guard pre-Katrina and its history; 2.) Identify the current treatment issues and obstacles faced by the National Guard and active military; and 3.) Discuss changes to the National Guard and active military policies that could address these issues.

SUMMARY:

Using the National Guard as a backdrop, this workshop will address programmatic and systemic disparities and inadequacies between the active duty military system and the National Guard system and how these disparities serve as barriers to the health and wellness of returning veterans. In addition, this workshop will confront issues in services to veterans of color, post-Katrina and Iraq who have been disproportionately damaged, underserved, unserved and in many cases, permanently harmed through systemic and culturally-incompetent neglect and disregard. This workshop makes recommendations for systemic change to foster resiliency and support to this population by advocating to treat the whole system which may include: family, leadership, units, and communities through a variety of methods to address issues such as: retention rates, marital conflicts, and avoidable crises.

REFERENCES:

1. Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning From Deployment to Iraq or Afghanistan, Charles W. Hoque; Jennifer L. Auchterlonie; Charles S. Milliken, JAMA, March 1, 2006; 295; 1023–1032.
2. Combat duty in Iraq and Afghanistan, mental health problem, and barriers to care. Hoge, C.W., Castro, C.A., Messer S.C., McGurk, P. Cotting, D.I. and Koffman, R.L. (2004); New England Journal of Medicine, 351, 13–22.

Workshop 19 **Friday, October 12**
10:00 a.m.-11:30 a.m.

WHO'S THE BOSS? LEADERSHIP SKILLS FOR PSYCHIATRY

APA Committee of Residents and Fellows

Molly K. McVoy, M.D., *Resident, Department of Psychiatry, University Hospitals of Cleveland, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106*; Justin B. Hunt, M.D.; Peter McVoy, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Define leadership styles and learn how to modify those styles; 2.) Outline assignments so that they are accomplished effectively; 3.) Express and receive feedback; and 4.) Manage difficult people and situations.

SUMMARY:

Do you want to become a leader? Do you have colleagues who are difficult to work with? Are you a chief resident or aspire to become a chief resident? Are you a psychiatric administrator and have to deal with managing people? Your leadership style is the basis from which you respond to each of these situations. Everyone has a preferred style and some styles are more effective than others. Improving your effectiveness will significantly improve patient care. In this workshop, you will have the opportunity to find out what your style is and what you can do to modify that style to become a more effective leader. Peter McVoy, is the president and founder of Visioneering Inc., a management consulting firm with a focus on leadership and organizational development. His recent clients include St. John Mercy Hospital, HMO Health Ohio, and Honda of America. He will speak on such topics as giving and receiving feedback, dealing with difficult people, and managing conflict in your residency or hospital. Bring one of your challenges with you and leave with the solution!

REFERENCES:

1. Blake, Robert R. and Mouton, Janse S. (1985). The Managerial Grid III: The Key to Leadership Excellence. Houston: Gulf Publishing Co.
2. Hall, Jay, (1980); The Competence Process, Managing for Commitment and Creativity; The Woodlands; Teleometrics International.

Workshop 20 — Friday, October 12, 10:00 a.m.-11:30 a.m.

VA RETURNING VETERANS CARE: PROGRAMS AND PROGRESS

APA VA Caucus

Laurent S. Lehmann, M.D., *Associate Chief Consultant, Department of Veteran Affairs, Mental Health Disaster, Post Deployment Activities, 810 Vermont Avenue, N.W., Washington, DC 20420-0001*; Harold S. Kudler, M.D.; Stacey Pollack, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Identify the unique needs of veterans returning from the war in Iraq and Afghanistan and their families; and 2.) Discuss a range of clinical services provided by the VA for these veterans and their families and data from delivery of these services.

SUMMARY:

Each presenter, including the Chair, will speak for 15 minutes followed by 10 minutes of discussion with participants. This will allow an additional 15 minutes, for discussion at the workshop's end. Dr. Lehmann will present national data on clinical services from the VA's Returning Veterans Outreach, Education and Care (RVOEC) teams. He will also discuss screening tools and approaches for risk stratification and follow-up. Dr. Pollack will discuss clinical data from the Washington, DC, the VA Medical Center War Stress program including service innovations for veterans and their families. Mental health issues of veterans with multiple physical injuries, including Traumatic Brain Injury, will be addressed. Dr. Kudler will discuss clinical service delivery activities of the Post Deployment Mental Illness Education Research and Clinical Center (MIRECC). His major focus will be on focus groups and survey data from veterans and their families, including analysis of health risk behaviors.

REFERENCES:

1. Iraq Clinician War Guide, 2nd Edition, July 2004, Dept. of Veterans Affairs, National Center for PTSD, Walter Reed Army Medical Center, www.ncptsd.va.gov.
2. Hoge CW, Auchterlonie JL, Milliken CS. Mental Health Problems, Use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan, JAMA, 2006. 295:1023–1032 .

Workshop 21 — Friday, October 12, 1:30 p.m.-3:00 p.m.

RESILIENCE AND THE STREETS: RECOVERY-ORIENTED SERVICES FOR HOMELESS PERSONS WITH MENTAL ILLNESS

2006–2008 APA/Bristol-Myers Squibb Fellows

Anthony J. Carino, M.D., *2006–2008 APA/Bristol-Myers Squibb Fellow; Liaison. APA/IPS Scientific Program Committee; and Resident, Department of Psychiatry, Montefiore Medical Center, Albert Einstein College of Medicine, 111 East 210th Street, Bronx, NY 10467*; Sarah C. Guzofski, M.D.; Ryan C. Bell, M.D., J.D.; Allison M. Nitsche, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) State the philosophy behind recovery-oriented psychiatric treatment and its application to people who are homeless; 2.) Use examples of recovery-oriented, evidence-based practices applicable to the treatment of homeless persons; 3.) Discuss outcome data from a Housing-First program, based on the recovery model; and 4.) Describe policy implications of designing psychiatric services, based on a recovery.

SUMMARY:

A recovery-oriented approach to psychiatric care challenges the treatment community to look beyond the goal of symptom management to create a collaborative relationship in which the patient's own goals guide treatment. A recovery-oriented philosophy may prove especially relevant to treating those with serious and persistent mental illness who are homeless. Many programs for this group require patients to follow provider-established steps to achieve provider-established goals. This approach is often unsuccessful and fosters the perception that this population is help-rejecting and difficult to treat. Increasingly, evidence-based outcomes suggest that homeless people with psychiatric and substance-related illnesses will accept and succeed in treatment, if this treatment is designed to meet self-identified needs in ways that are acceptable to them. The presenters we will provide an overview of the evidence favoring a range of recovery-oriented services for this population, utilizing case examples and an in-depth look at the outcomes from a Housing-First program built around this philosophy. They we will then discuss the pragmatic and policy implications, as well as the limitations, of recovery-oriented services for homeless persons with substance related and psychiatric illness.

REFERENCES:

1. Wright NM: How can health services effectively meet the health needs of homeless people? Br J Gen Pract 2006; 56: 286–93.
2. Sowers W: Transforming systems of care: the American Association of Community Psychiatrists guidelines for recovery oriented services. Community Mental Health Journal 2005; 41:757–74.

Workshop 22 **Friday, October 12 1:30 p.m.-3:00 p.m.**

SUICIDE IN DIVERSE POPULATIONS POST DISASTER: MYTH OR REALITY?

OMNA on Tour in the Gulf Coast Track

William B. Lawson, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Howard University College of Medicine and Hospital, 2041 Georgia Avenue, N.W., Washington, DC 20060*; Donna Barnes, Ph.D.; Henry Westray; Jeffrey C. Rouse, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Recognize the key elements of a successful suicide prevention program; 2.) List the challenges associated with defining the suicide rate in a post-disaster metropolitan area; and 3.) Identify differential patterns of suicide in various ethnic groups.

SUMMARY:

Since Hurricane Katrina hit in August 2005, there was fear of sharp increases in suicide rates in the Gulf Coast. There have been conflicting reports of the change in the suicide rate. A closer examination of suicide reporting post-Katrina may reveal a more complicated picture due to devastation to the general infrastructure, loss of pre-Katrina records, underreporting and failed attempts. This workshop will also examine diversity and cultural dynamics of suicide. An evidence-based suicide prevention strategy will be presented as a model.

REFERENCES:

1. Joe S, et.al; Prevalence of and risk factors lifetime suicide attempts among blacks in the U.S. JAMA. 2006; 296:2112–2123.
2. Aseltine RH, DMartino R. An outcome evaluation of the SOS suicide prevention program. American Journal of Public Health, March 2004, Vol. 94, No. 3, 446–451.

Workshop 23 **Friday, October 12 1:30 p.m.-3:00 p.m.**

DISASTER PLANNING: PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

APA Caucus of Psychiatrists Working in Correctional Settings

Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*; Chanson D. Noether, M.A.; William Arroyo, M.D.; Tom Hamilton, Ph.D.; Cassandra F. Newkirk, M.D.; Fred C. Osher, M.D.; Erik J. Roskes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) List the need for, complexity of, and the details of disaster planning for persons with mental illness in the criminal justice system; and 2.) Describe the details of the mental health aspect of the facilities disaster plan, including the responsibilities of the mental health staff, cross training with security staff, evacuation procedures, regular drills, etc.

SUMMARY:

The shock of the Katrina hurricane catastrophe mobilized the mental health community to undertake planning for future disasters. However, one group that has received virtually no attention are those persons with mental illness in jails and prisons. Jails, in particular, are impacted by disasters. They may be small with little in the way of mental health services and detainees may be just off the street with many medical and psychiatric urgencies. Loss of inmate records, both legal and mental health, and the status of their legal situation are complicated. Sub-groups within this population require special planning: youth in adult facilities, women, the dually diagnosed, the elderly, the developmentally disabled and importantly, the families of inmates. This workshop will build on what happened to such inmates (as demonstrated by excerpts of letters from "Prisoners Abandoned to Katrina" submitted to Human Rights Watch) and will seek to develop plans for assuring the proper care for this extremely vulnerable group. The "Emergency Response Plan" Standard of the National Commission on Correctional Health Care, as applied to inmates with mental illness, will be used as a start of a model of planning. This interactive workshop will be relevant to all mental health professionals who are involved with persons with mental illness in jails and prisons.

REFERENCES:

1. American Psychiatric Association: Disaster Psychiatry Web Site: Disaster Psychiatry Links: Disaster

Psychiatry: How to Cope http://www.psych.org/disasterpsych/links/weblinks.cfm.
2. National Commission on Correctional Health Care, (2003) Standards for Health Services in Jails, NCCHC, Illinois, Standard J-A-07 - Emergency Response Plan, p.13 - 15.

Workshop 24 **Friday, October 12 1:30 p.m.-3:00 p.m.**

TOWARDS AN INTEGRATED LONGITUDINAL PSYCHOTHERAPY CURRICULUM

Michael D. Garrett, M.D., *Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center; and Clinical Associate Professor of Psychiatry and Faculty, Psychoanalytic Institute at New York University Medical Center, 243 West 98th Street, Apt. 7-B, New York, NY 10025-5566*; Stephen M. Goldfinger, M.D.; Ellen Berkowitz, M.D.; Azziza O. Bankole, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define critical domains in psychotherapy training and provide multiple rationales for ordering this training over the four-year residency experience.

SUMMARY:

RRC requirements for psychotherapy training during residency have been perhaps the most shifting target in the curriculum. From a position of requiring exposure to specific modalities and interventions to our current competency based model, attention seems to be focused on a 'check-list' approach. What are, and what should be, the skills residents must acquire for the non-pharmacologically based treatment of their patients? Clearly, exposure to history-taking, assessment of mental status and interpersonal functioning, and examinations of their own, and their patients' feelings are essential. Mastering basic psychodynamic theory and operational principles are generally seen as mandatory, as is a grasp of cognitive behavioral interventions. We expect exposure to individuals, couples and groups. We must teach culturally and linguistically appropriate approaches, while also considering our residents' own ethnic, ideological and personal frames. How are we to move from this "smorgasbord" approach to a logical sequence of increasingly complex skills sets appropriate to trainees' clinical rotations and professional development? Is there an inherent ordering of psychotherapy skills, and how can we integrate our individual courses and content areas to maximize this hierarchical development? This approach has been the focus of a task force at SUNY Downstate. Promising no solutions, this workshop will, we hope, serve as a jumping off point for discussion of how we as educators can integrate our 'talking with patients' curricula into a more rational program of study and skill acquisition.

REFERENCES:

1. Glenn Gabbard. Long-Term Psychodynamic Psychotherapy. A Basic Text. American Psychiatric Publishing. 2004.
2. Bernard D. Beitman and Dongmei Yue. Learning Psychotherapy: A Time-Efficient, Research-Based, and Outcome-Measured Psychotherapy Training Program, Second Edition W. W. Norton 2004.

Workshop 25 **Friday, October 12 3:30 p.m.-5:00 p.m.**

THE PUBLIC PERCEPTION OF PSYCHIATRY: WHY IT MATTERS, WHAT'S BEING DONE, AND FUTURE IMPLICATIONS FOR OUR PRACTICE

2006–2008 APA/Bristol-Myers Squibb Fellows

Patrick S. Runnels, M.D., *2006–2008 APA/Bristol-Myers Squibb Fellow; and Resident, Department of Psychiatry, Mount Sinai Hospital, 1245 Park Avenue, #3E, New York, NY 10128*; Elissa Miller, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a greater understanding of the impact of positive and negative media on the field of psychiatry, as well as a working knowledge of current APA media initiatives and data supporting these campaigns.

SUMMARY:

The public perception of both mental illness and the people who treat it greatly impacts the ability to deliver effective mental health care. Increasingly, the public is bombarded by an almost constant barrage of negative images and stereotypes about mental illness in major media – from Dr. Hannibal Lecter in "Silence of the Lambs" to Matt Lauer's infamous interview with Tom Cruise on the Today Show in 2005. Recent studies demonstrate that this attention has indeed had a negative impact. In response, multiple agencies, including the APA, have initiated campaigns targeting these very stigmas. This workshop will review data about the public perception of mental illness, highlight several initiatives (both local and national) aimed at addressing and reducing stigma, and explore the effectiveness of such campaigns.

REFERENCES:

1. Cutcliffe JR, Hannigan B: Mass media, "monsters" and mental health clients. The need for increased lobbying. Journal of Psychiatric and Mental Health Nursing, 8(4), 315–321, 2001.
2. Diefenbach DL: The portrayal of mental illness on prime-time television. Journal of Community Psychology, 25(3), 289–302, 2005.

Workshop 26 **Friday, October 12 3:30 p.m.-5:00 p.m.**

PSYCHIATRY GETS IN BED WITH PRIMARY CARE: TRAINING MODELS IN CLINICS AND HOSPITALS

American Association of Community Psychiatrists

Russell F. Lim, M.D., *Associate Clinical Professor, and Director of Diversity Education and Training, Department of Psychiatry and Behavioral Sciences, University of California Davis School of Medicine, 2230 Stockton Boulevard, Sacramento, CA 95817*; John C. Onate, M.D.; Glen Xiong, M.D.; Robert M. McCarron, D.O.; Sarah K. Rivelli, M.D.; Jeffrey T. Rado, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) List the advantages of primary care training sites in psychiatric residency to teach collaborative and psychiatric care and the role of the medicine psychiatry unit in the training of residents; and 2.) Recognize the unique role that combined trained faculty can have in outpatient and inpatient community medicine.

SUMMARY:

Psychiatric patients have high rates of medical illness and there is limited outpatient general internal medicine training in psychiatric residency. We will discuss a rotation developed by the University of California Davis in which psychiatry residents provide medical and psychiatric care to patients with co-morbid mental and medical illness in a county primary care clinic, the medicine-psychiatry clinic at Rush University and the medicine-psychiatry inpatient service at Duke University Medical Center. The patient population admitted to this inpatient medicine ward comprises patients who have comorbid psychiatric conditions. The psychiatry residents rounding on these services learn about the unique medical conditions of the mentally ill, in addition to general medical conditions, from dually trained faculty who are sensitive to both the medical and psychiatric needs of patients. Application of combined trained faculty expertise in both the inpatient and outpatient settings will be discussed in an interactive format with a focus on collaboration. The workshop will be of interest to an audience of psychiatrists, practicing in community settings, who work with an underserved patient population who have limited primary care and psychiatric care access, as well as academic psychiatrists involved in the training of psychiatry residents or combined medicine/family practice and psychiatry residents.

REFERENCES:

1. Doebbeling CC, Felker BL, O'Connor MK. Mental health care in primary care settings. Psychosomatics. 2004;45(3):272.
2. Swartz MS, Swanson JW, Hannon MJ, et al: Regular Sources of Medical Care Among Persons With Severe Mental Illness at Risk of Hepatitis C Infection. Psychiatric Services 54(6): 854–859, 2003.

Workshop 27 **Friday, October 12 3:30 p.m.-5:00 p.m.**

THE STORM BEFORE THE STORM: CORRECTIONS, MENTAL HEALTH, AND PEOPLE OF COLOR

OMNA on Tour in the Gulf Coast Track

Cassandra F. Newkirk, M.D., *Director of Mental Health Services, GeoCare, Inc., 22306 Misty Woods Way, Boca Raton, FL 33428*; Denese Shervington, M.D., *664 Route 9, West, Nyack, NY 10960*; James E. Lee, M.D.; Cheryl D. Wills, M.D.; Gerry Gibbs, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Recognize the impact of disaster on the correctional system and mental health services provided therein; 2.) Discuss the high rates of incarceration among adults and juveniles of color in the U.S.; 3.) Recognize the degree to which unmet mental health needs predispose to correctional institutionalization of people of color; and 4.) List strategies for jail diversion and prevention of unnecessary incarceration in people with unmet mental health needs.

SUMMARY:

This workshop will address the intersection between unmet mental health needs and people in the adult correctional system and the juvenile justice system in the New Orleans metropolitan area and other parts of the Gulf Coast. Across the country, there is great concern about the criminalization of mental illness, especially within populations of color and people of low socioeconomic status. This situation is magnified to even greater proportions in the context of disaster. The presenters will speak to their experiences in caring and overseeing services for these populations in a pre- and post-disaster context

and offer strategies and recommendations to prevent unnecessary incarceration and improve mental health services among adult and youth detainees.

REFERENCES:

1. Braithwaite R, Arriola K, Newkirk, C: Health Issues Among Incarcerated Women: Rutgers University Press, 2006.
2. Primm AB, Osher F, Gomez M: Race and Ethnicity, Mental Health Services and Cultural Competence in the Criminal Justice System: Are we Ready to Change? Community Mental Health Journal 2005; 41(5): 557–569.

Workshop 28 **Friday, October 12 3:30 p.m.-5:00 p.m.**

OPPOSITION TO MENTAL HEALTH SCREENING: A STRATEGIC RESPONSE

Laurie M. Flynn, *Director, Carmel Hill Center, and Department of Psychiatry, Columbia University, Division of Child and Adolescent Psychiatry, 1775 Broadway, Suite 715, New York, NY 10019*; David Shern, Ph.D.; Darcy Gruttadaro, J.D.; Meghan Gutierrez

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Recognize the problem of unidentified mental illness in youth; 2.) Define the nature and tactics of the opposition to mental health screening; 3.) Identify inaccuracies about mental health screening and the Columbia University TeenScreen Program put forth by critics of mental health screening; 4.) Develop strategies for influencing public understanding of mental illness in youth and mental health screening programs; and 5.) Design strategies for dealing with attacks on mental health programs by groups with anti-mental health agendas.

SUMMARY:

An overwhelming majority of youth with mental illness in this country remains unidentified. Consequently, they remain at risk for suicide, lowered academic and occupational attainment, and many other adverse outcomes. The President's New Freedom Commission on Mental Health recommended screening for early identification of mental illnesses and cited the Columbia University TeenScreen Program as a model program. The release of the New Freedom Commission's final report and the passage of the Garrett Lee Smith Memorial Act, which provided the first federal funds for early identification programs, including mental health screening, have resulted in greater public attention given to mental health programs for youth. The increased visibility of mental health screening has resulted in organized opposition against early identification efforts and screening programs by groups with anti-mental health agendas. The presentations will: 1.) Describe the prevalence and consequences of unidentified mental illness in youth; 2.) Describe the TeenScreen program; and 3.) Describe who is behind the anti-screening movement and the tactics they employ. Workshop discussion will focus on strategies for: 1.) Influencing public understanding of mental illness in youth and mental health screening programs; and 2.) Addressing campaigns of misinformation carried out by those with an anti-mental health agenda.

REFERENCES:

1. Friedman RA: Uncovering an Epidemic - Screening for Mental Illness in Teens. N Engl J Med 2006; 355:2717–2719.
2. Weist MD, Rubin M, Moore E, Adelsheim S, Wrobel G: Mental Health Screening in Schools. J Sch-Health 2007; 77(2):53–58.
3. Shaffer D, Scott M, Wilcox H, Maslow C, Hicks R, Lucas CP, Garfinkel R, Greenwald S: The Columbia Suicide Screen: validity and reliability of a screen for youth suicide and depression. J Am Acad Child Adolesc Psychiatry 2004; 43(1):71–9.

Workshop 29 **Friday, October 12 3:30 p.m.-5:00 p.m.**

WHAT'S NEW IN ADDICTION PHARMACOTHERAPY? USING MEDICATIONS TO ENHANCE RECOVERY

APA Council on Addiction Psychiatry

John A. Renner, M.D., *Associate Professor of Psychiatry, Boston University School of Medicine, VA OPC, 251 Causeway Street, Boston, MA 02114*; Petros Levounis, M.D., M.A.; Christopher J. Welsh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and treat substance-dependent patients who would benefit from the addition of pharmacotherapy to their relapse prevention treatment program.

SUMMARY:

During the last decade, a number of new medications have received FDA approval for the treatment of substance abuse. The focus of this presentation will be on medications used to promote sobriety and/or relapse prevention in individuals dependent on alcohol, nicotine, stimulants, and opiates. Presenters will review the pharmacology, mechanisms of action, and protocols for utilizing these medications in outpatient clinical practice. Guidelines will be provided for integrating pharmaco-

therapy into psychotherapy and twelve-step recovery programs. Discussion will also include other promising agents currently under study for the treatment of these conditions.

REFERENCES:

1. O'Brien CP, Koob GF, Mee-Lee D, Rosenthal RN. New developments in addiction treatment. J Clin-Psychiatry 67:11,1801–1812, 2006.
2. McCance-Katz EF. Office-based buprenorphine treatment for opioid-dependent patients. Harv Rev-Psychiatry 12(6):321–338, 2004.

Workshop 30 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

MEDICAL COMORBIDITY IN A DUAL DIAGNOSIS UNIT

Vasant P. Dhopesh, M.D., *Department of Psychiatry, VA Medical Center, University and Woodland Avenues, Philadelphia, PA 19104*; Jeanne Cunningham, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define the common medical issues and their management among dually diagnosed patients.

SUMMARY:

This workshop is designed for practioners in dual diagnosis settings. This will be a real world review of medical problems associated with dual diagnosis. Active participation by the audience will be encouraged. Some basic and general knowledge of internal medicine is sufficient. Dual diagnosis patients are at high-risk for medical co-morbidities and are frequent users of primary care and a large amount of consultative services, contributing substantially to health care cost. Previously, we reported that 40% of patients on our dual diagnosis unit had at least one consult request and 60% required more than one consultation. This workshop will focus on the critical importance of recognition and management of medical disorders encountered in this population. Interesting cases with unusual pathology will be illustrated.

REFERENCES:

1. Felker B, Yagel B, Short D: Mortality and medical comorbidity among psychiatric patients: A review. Psychiatry Services 47:1356–1363,1996.
2. Rubin RB, Neugaten J. Medical Complications of cocaine: Changes in pattern of use and spectrum of complications; J. Toxcal Clin Toxical 30,1–12,1992.

Workshop 31 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

THE PATH HOME FOR THE ELDERLY: UNDERSERVED ELDERLY POPULATIONS OF POST-KATRINA GULF COAST

OMNA on Tour in the Gulf Coast Track

Elliott Hill, L.C.S.W., BCD, *Consultant, E. Hill & Associates, LLC, 2221 Peachtree Road, Suite D-178, Atlanta, GA 30309*; Paul Metoyer, M.S.W.; Janice Beal, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) Explain a number of medical issues that have intensified post-Katrina and the effects that they have had on mood and emotion in the elderly population; and 2.) Identify behavioral characteristics and symptoms of depression in elderly populations, including early symptoms of Alzheimer's Disease/Dementia.

SUMMARY:

This session will identify and address the challenges in providing mental health services to the elderly and aging populations of post-Katrina New Orleans and the Gulf Coast. Additionally, medical issues were exacerbated after the storms and have negative effects on mood and cognition in elderly populations.

REFERENCES:

1. Berggren, Ruth E., Curiel, Tyler J.: After the Storm-Healthcare Infrastructure in Post Katrina New Orleans, N Engl J Med 2006 354:1540–1552.
2. Holtzman R.E., Rebock G.W., Sacynski J.S., Kouzic A.C., Wilcox Doylek, Eaton W.W.,: Social Network Characteristics and Cognition in Middle Aged and Older Adults. J Gerontol Psyhol Sci Soc Sci. 2004; 59B: P278–284. Pub Med ID: 15576855.

Workshop 32 **Saturday, October 13 8:00 a.m.-9:30 a.m.**

CONTINOUS RECOVERY RELATIONSHIPS: DUTCH TREATMENT

Rene C.A. De Veen, M.D., *Psychiatrist, Mediant, Saffierstraat 15, Boekelo 7548CC Netherlands*; Johanna Van Den Hoed, M.D.; Michel Ten Buuren; Yvonne Hekkink; Hans Agelink, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe new opportunities for delivering continuous psychiatric care for persons with chronic psychiatric illnesses.

SUMMARY:

In the U.S., clinical care for psychiatric patients and outpatient programs often seem like 'separate universes'. Insurance issues and complicated application procedures for different types of programs often create a situation in which continuity of care is difficult to provide. Consumers get lost in the jungle of possibilities ánd restrictions, care-providers often feel they 'patch up' rather than 'heal'. In The Netherlands, this situation is not uncommon as well, but ways to avoid this have been found. In this workshop, we will present a Dutch model of delivering care to persons with chronic psychiatric illnesses, in which outpatient care, day care, clinical admissions, and respite-facilities are welded together in a way that provides continuous care over many years. Variations on this theme are being presented by a psychiatrist and a case manager who provide this type of combined inpatient and outpatient care. A consumer will present the benefits of the system from the consumers perspective. A U.S. psychiatrist will participate in the panel discussion. The results of ten years of experience with this model in Mediant, a health care institution in the east of The Netherlands, will be presented. Recommendations for introduction of this method in the U.S. will also be addressed.

REFERENCES:

1. Farragher B, Carry T, Owens J: Long-term follow-up of rehabilitated patients with chronic psychiatric illness. Psych Serv Journal 1996, 47:1120–1122.
2. Druss BG, Rohrbaugh RM, Levinson CM, Rosenheck RA. Integrated medical care for patients with serious psychiatric illness; Arch Gen Psychiatry. 2001; 58:861–868.

Workshop 33 **Saturday, October 13**
8:00 a.m.-9:30 a.m.

RECOVERY: HOW TO INVOLVE FAMILY MEMBERS IN THE RECOVERY PROCESS

Association of Family Psychiatrists

Alison M. Heru, M.D., *Director of Family Programs, Department of Psychiatry, Butler Hospital/Brown University, 345 Blackstone Boulevard, Providence, RI 02906*; John Sargent, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Identify the knowledge base, attitudes, and skills needed to work with patients and families; and 2.) Describe how to manage difficult family situations.

SUMMARY:

Evidence-based research has determined that family factors have a powerful influence on mental health and recovery. In adult psychiatry training, the goal is to develop practitioners who can work effectively with family members within a systems perspective, rather than advanced family therapists. This workshop outlines a knowledge base for working with patients and their families. This includes an understanding of how family functioning influences psychiatric illness and recovery patterns and demonstrates how to integrate this understanding into a biopsychosocial formulation and treatment plan. This workshop outlines the attitudes needed to establish a collaborative working alliance with the patient and family.

REFERENCES:

1. Committee on the Family, Group for the Advancement of Psychiatry. Family Skills for General Psychiatry Residents: Meeting ACGME Core Competency Requirements. Academic Psychiatry 2006 Spring; 30(1):69–78.
2. Heru AM. Family Psychiatry: From Research to Practice. American Journal of Psychiatry 2006; 3: 962–968.

Workshop 34 **Saturday, October 13**
10:00 a.m.-11:30 a.m.

THE OTHERS: POLYSUBSTANCE ABUSE IN ADOLESCENTS-BEYOND TOBACCO, ALCOHOL, AND MARIJUANA

American Academy of Child and Adolescent Psychiatry, Committee on Substance Abuse and Addictions

Terri L. Randall, M.D., *Resident, Department of Child and Adolescent Psychiatry, The Children's Hospital of Philadelphia, 3440 Market Street, Suite 200, Philadelphia, PA 19104*; Eugene Lee, M.D.; Laila F.M. Contractor, M.D.; Ramon Solhkhah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Define the major issues facing the evaluation and treatment of adolescents with polysubstance use disorders; and 2.) Recognize primary, secondary, and tertiary prevention strategies for adolescent substance use disorders.

SUMMARY:

Adolescent substance use is an important and costly public health problem. The majority of adolescents who abuse substances use more than one drug. The most frequent drugs of abuse are alcohol, marijuana, and to-

bacco. However, adolescents use a variety of other drugs, as well. The goal of this workshop is to familiarize the attendees with other substances of abuse, such as MDMA (methylenedioxymethamphetamine)/ecstasy and methamphetamine/crystal meth. In addition, we will present treatment and prevention strategies that address these substances.

REFERENCES:

1. Goldsamt LA, O'Brien J, Clatts MC, McGuire LS. The relationship between club drug use and other drug use: a survey of New York City middle school students. Substance Use & Misuse 2005;40(9–10): 1539–55.
2. Henggeler SW, Clingempeel WG, Brondino MJ, Pickrel SG. Four-year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders. Journal of the American Academy of Child & Adolescent Psychiatry 2002; 41(7):868–74.

Workshop 35 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

MOBILIZING RESOURCES TO ELIMINATE PRE-EXISTING AND POST-DISASTER HEALTH AND MENTAL HEALTH DISPARITIES: THE REGIONAL COORDINATING CENTER FOR HURRICANE RESPONSE AT MOREHOUSE SCHOOL OF MEDICINE

OMNA on Tour in the Gulf Coast Track

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Phyllis Harrison-Ross, M.D.; Ayanna V. Buckner, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Define the health and mental health disparites amongst medically underserved populations that existed in the South and Gulf Coast prior to the storm; and 2.) Identify the impact of activities, collaborations, outcomes and opportunities that have emerged from the Regional Coordinating Center for Hurricane Response.

SUMMARY:

This presentation will describe the response of Morehouse School of Medicine to the Gulf Coast disaster of 2005. Through its Centers of Excellence on Health Disparities at the National Center for Primary Care, Morehouse School of Medicine was funded by the U.S. Department of Health and Human Services, Office of Minority Health with support from the National Institutes of Health, National Center on Minority Health and Health Disparities, to coordinate the work of all of the Centers of Excellence on Health Disparities in the southeast region in rebuilding and enhancing the health infrastructure in the areas impacted by Hurricanes Katrina and Rita. The project, titled the Regional Coordinating Center for Hurricane Response, is responding to the devastation in the health care infrastructure in the region by mounting an effort to conduct community surveillance and screening and to facilitate the provision of general health and mental health services to disaster-affected people in Louisiana, Mississippi, Alabama, and Texas. An essential aspect of this grant is to establish partnerships with NIH Centers of Excellence at several institutions, including Historically Black Colleges and Universities (HBCUs) across the South. One of the key methods employed in this effort is telepsychiatry, which will be evaluated to determine its potential for eliminating disparities in mental health care across diverse medically underserved populations. Morehouse School of Medicine has a partnership with the All Healers Mental Health Alliance (AHMHA), a group of mental health professionals and other health advocates designed to create a network of culturally competent mental health professionals poised to provide services to devasted communities where disparities in access to mental health care predated the disaster.

REFERENCES:

1. Gooden, RA. After the Storm: Visions of a Revitalized Health Care System. Atlanta, Georgia: Morehouse School of Medicine; April 2006.
2. U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institutes of Mental Health.

Workshop 36 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

EFFECTIVE ADVOCACY FOR PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

APA Committee on Jails and Prisons

Fred C. Osher, M.D., *Director, Health Systems and Services Policy, Council of State Governments; and Former APA/Bristol-Myers Squibb Fellow, 15221 Manor Lake Drive, Rockville, MD 20853-1562*; Henry C. Weinstein, M.D.; Tom Hamilton, Ph.D.; William Arroyo, M.D.;

Cassandra F. Newkirk, M.D.; Erik J. Roskes, M.D.; H. Richard Lamb, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Define the principles of effective advocacy for persons with mental illness in the criminal justice system by utilizing the five steps of the Advocacy Handbook; and 2.) Develop strategies for successful advocacy initiatives working with peers, partners, and the media.

SUMMARY:

The overrepresentation of persons with mental illnesses in the criminal justice system is a phenomenon that cries out for alternatives to incarceration and linkage to effective mental health treatment for those affected. An increased understanding of the factors contributing to this overrepresentation and strategies to reduce the presence of persons with mental illness in these settings is imperative. Building on the work of CSG, NAMI, NASMHPD, NMHA, and the Bazelon Center who developed an Advocacy Handbook for Persons with Mental Illness Involved in the Criminal Justice System, the APA Committee on Criminal Justice, will describe it's efforts to promote an advocacy agenda at the District Branch level. Committee members will provide an overview of the phenomenon, describe effective strategies now being implemented, and discuss mechanisms for using the Advocacy Handbook in local District Branch efforts. The target audience for this workshop is all psychiatrists and mental health professionals interested in addressing the socio-legal aspects of mental illness.

REFERENCES:

1. Council on State Governments: The Advocacy Handbook (2005) Access at: www.Consensusproject.org/advocacy.
2. The American Psychiatric Association's Advocacy Action Center: Access at: http://www.capitolconnect.com/apa/default.aspx.

Workshop 37 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

COMMUNITY PSYCHIATRY EDUCATION AND TRAINING: PROGRAMS AND PARTNERSHIPS

American Association of Community Psychiatrists

Richard C. Christensen, M.D., M.A., *Clinical Associate Professor, and Director, Community Psychiatry Program, Health Science Center, University of Florida College of Medicine; and Former APA/Bristol-Myers Squibb Fellow, 655 West 8th Street, Jacksonville, FL 32209*; Michael T. Compton, M.D., M.P.H.; Lorrie K. Garces, M.D.; Raymond J. Kotwicki, M.D., M.P.H.; Robert J. Ronis, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss the different educational models, and public sector-academic funding partnerships, being utilized in the United States to train physicians to assume leadership roles in community and public sector psychiatry.

SUMMARY:

Although the President's New Freedom Commission on Mental Health highlighted the significant need to recruit, train and retain psychiatrists who are committed to working in community mental health, formal training opportunities in public sector psychiatry are still not widely available in the United States. This workshop will highlight several different training models in community psychiatry that have been developed in recent years and will address mechanisms of funding for these specific programs. Drs. Compton and Kotwicki will describe the Emory University School of Medicine Fellowship in Community Psychiatry/Public Health, a unique training program for early career psychiatrists. This training opportunity combines clinical/administrative rotations in community mental health, legislative/policy opportunities, psychiatric research experience, longitudinal mentoring, a didactic/site visit series, and formal course work at the Rollins School of Public Health at Emory University leading to a Master of Public Health degree. Dr. Ronis will discuss the Professor of Public Psychiatry Program in Ohio, which serves as a model public sector-academic partnership. He will address the evolution of this collaboration, the manner in which it provided initial funding for community psychiatry education, and the subsequent development of other training initiatives. Dr. Garces will conclude with a personal assessment of pursuing a Fellowship in Community Psychiatry at the University of Florida and how this experience, as well as those derived from undergraduate medical education at the University of Wisconsin, shaped her career path. Throughout the workshop, audience participants will be encouraged to share their own experiences of community psychiatry training, perceived obstacles to program development, and potential solutions regarding funding options.

REFERENCES:

1. Svendsen DP, Cutler DL, Ronis RJ et al.: The Professor of Public Psychiatry Model in Ohio: The Impact on Training, Program Innovation, and the Quality of Mental Health Care. Community Mental Health Journal 2005; 41(6): 775–784.

2. Christensen RC: Community Psychiatry and Medical Student Education. Psychiatric Services 2005; 56(5): 608–09.

Workshop 38 **Saturday, October 13 10:00 a.m.-11:30 a.m.**

LOW TECH/HIGH TECH: SHELTER ROTATIONS FOR OUTPATIENT TRAINING

Stephen M. Goldfinger, M.D., *Chair, APA/IPS Scientific Program Committee; and Chair, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Van Yu, M.D.; Ellen Berkowitz, M.D.; Dillon C. Euler, M.D.; Azziza O. Bankole, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the value of including an outpatient shelter rotation into residency training and develop online curricula for this and other educational courses.

SUMMARY:

The residency training program at the State University of New York, Downstate Medical Center (DMC) is, to our knowledge, the only training program in the U.S. with a required rotation in homeless shelters as part of the outpatient training experience. In collaboration with the Project for Psychiatric Outreach to the Homeless, Downstate has, for the past six years, had residents spending a half-day a week working in various shelter settings throughout New York City. Most cities have a pair of residents assigned; experiences range from more traditional psychiatric evaluations to cooking groups, 'how to get more sex' (. . .start with ADLs!) groups to community outreach to street-dwellers on a mobile van. Sites range from relatively stable SROs serving the elderly or single women with children to short-term emergency shelters where worman are assigned chairs in which to sleep. Direct supervision is provided by PPOH physician staff on-site, with bi-weekly group supervision shared by PPOH and Downstate clinicians. In addition to DMC trainees, volunteer residents and those doing electives from other New York training programs also work in city shelters. One of the challenges was providing essential didactics to these widely scattered trainees, exposing them to the extensive clinical and sociological literature on mental illness and homelessness. Each week, an article is sent out in an e-mail to all residents, with one of them responsible for providing a summary of the reading. This summary, as well as Dr. Yu's own analysis of the implications of the piece, are distributed to the entire mailing list.

REFERENCES:

1. Cohen N, McQuistion H, Albert G. et. al; (1998) Training in Community Psychiatry: New Opportunities, Psychiatric Quarterly 69(2):107–116.
2. Susser E, Goldfinger SM, White A. Some Clinical Approaches to Work With the Homeless Mentally Ill. Community Mental Health Journal 1990; 26(5):468–480.

Workshop 39 **Saturday, October 13 1:30 p.m.-3:00 p.m.**

THE USE OF TELEPSYCHIATRY IN THE POST-DISASTER GULF COAST

OMNA on Tour in the Gulf Coast Track

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Phyllis Harrison-Ross, M.D.; Charlyn A. Hilliman, Ph.D., M.P.A.; Norwood Knight-Richardson, M.D., M.B.A.; Thomas J. Kim, M.D., M.P.H.; Sue Bailey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Describe how videoconferencing works in the clinical setting; 2.) Identify key features of the telepsychiatry training process which enhance the work of mental health case managers; and 3.) List the benefits and pitfalls of the use of this technology for teaching and training non-medical personnel.

SUMMARY:

This presentation will describe the use of telepsychiatry to increase access to mental health care and compensate for mental health practitioner shortages in the Gulf Coast following Hurricanes Katrina, Rita and Wilma. Presenters will discuss the usage of this modality to provide clinical care to patients in a variety of remote settings, and consultation and training of primary care practitioners and case managers. The discussion will also focus on the logistics of establishing telepsychiatry services in areas with limited infrastructure and limited technical support. The various challenges associated with providing telepsychiatry will be presented and the implications of these challenges for the future of psychiatric services in rural, remote and other mental health professional shortage areas will be discussed.

REFERENCES:
1. Hilty D, Nesbitt T, Marks S, Callahan E. Effects of telepsychiatry on the doctor-patient relationship: communication, satisfaction, and relevant issues. Primary Psychiatry 2002; 9:29–34.
2. Stevens A, Doidge N, Goldtloom D, Voore P, Farewell J. Pilot Study of televideo psychiatric assessments in an underserviced community. American Journal of Psychiatry 1999; 156: 783–785.

Workshop 40 **Saturday, October 13 1:30 p.m.-3:00 p.m.**

PRACTICAL CHALLENGES IN PERSON-CENTERED SERVICE PLANNING

American Association of Community Psychiatrists

Neal H. Adams, M.D., M.P.H., *Director of Special Projects, California State Department of Mental Health, 4129 Cherryvale Avenue, Soquel, CA 95073*; Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) List the principles of person centered planning; 2.) Describe the relationship of the treatment plan and medical necessity; and 3.) Recognize how level of care and treatment planning can be facilitated with computerized records.

SUMMARY:

There is increasing recognition of the importance and value of treatment planning in mental health practice to honor the commitment to be person-centered and recovery oriented; to meet regulatory/payer requirements; and to assure access to effective treatment and promote outcomes. In many respects person-centered treatment planning is synonymous with recovery approaches to psychiatric rehabilitation. This workshop will focus on two issues related to treatment planning: 1.) Resolving the tension of serving two masters and strategies for being person-centered and recovery oriented while demonstrating the medical necessity of services and other licensing/accreditation requirements; and 2.) An examination of how the movement toward electronic medical records (EMRs) might challenge engagement and person centered care and how supposed barriers of EMR's may be transformed into tools to overcome the barriers to the provision of person centered care using the LOCUS M-POWER planner as an example.

REFERENCES:
1. Adams, N. and Grieder, D. Treatment Planning for Person-Centered Care, Elsevier Academic Press, 2004.
2. Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, Washington D.C., 2005.

Workshop 41 **Saturday, October 13 1:30 p.m.-3:00 p.m.**

NATURAL DISASTERS: THE EFFECTS OF RACISM ON TRAUMA RESPONSE IN PEOPLE OF AFRICAN DESCENT

APA Minority Fellowships Program

Napoleon B. Higgins, Jr., M.D., *Chief Executive Officer, Child, Adolescent, and Adult Psychiatry Department, Bay Pointe Behavioral Health Service, Inc., 1560 W. Bay Area Boulevard, #110, Friendswood, TX 77089*; Lacresha L. Hall, M.D.; Aruna S. Rao, M.D.; Eric R. Williams, M.D.; Jean-Marie E. Alves-Bradford, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Describe how natural disasters affect African communities; 2.) Recognize how racism affects trauma response; and 3.) Identify treatment and outreach efforts to improve care to ethnic diverse communities affected by natural disasters.

SUMMARY:

The purpose of this workshop is to present a novel minority perspective on issues regarding natural disasters. We will specifically focus on trauma response in communities of African descent. Currently, psychiatry is focusing on cross cultural differences and disparities in treatment, assessment and diagnosis in minority groups. What makes this workshop unique is that it will distinctively concentrate on how trauma response differs in communities where the majority of the population is of African descent. The presenters will discuss how trauma response differs in African communities, as well as how racism and lack of concern effects the trauma response within these communities. By the end of this workshop, the participant will know how racism effects trauma response, how natural disasters shape Black communities in both Africa and America and facilitate exchange between mental health professionals and the African diaspora. With this seminar we hope to advance intervention, education and advocacy for trauma response in people of African descent.

REFERENCES:
1. McKenry P, Price S, (eds): Families and Change. Sage Publications: 2005.
2. D J Parker (ed.): Vulnerability Analysis and Disasters. Cannon T., Floods. Routledge: 2000.

Workshop 42 Saturday, October 13
3:30 p.m.-5:00 p.m.

ALL HEALERS MENTAL HEALTH ALLIANCE: BRINGING HOPE AND HELP IN TIMES OF DISASTER AND ALL HAZARDS

OMNA on Tour in the Gulf Coast Track

Phyllis Harrison-Ross, M.D., *Emeritus Professor of Psychiatry and Behavioral Health Sciences, New York Medical College; and Managing Partner, Black Psychiatrists of Greater New York and Associates, 41 Central Park West, # 10-C, New York, NY 10023*; Lucy Perez, M.D.; Silas Buchanan; Darcel Suite, M.S.; Mae Jackson

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Discuss the importance of collaboration across disciplines and organizations in the development of a nationwide effort to increase access to mental health services and support recovery and resilience in the Gulf Coast; and 2.) Recognize the value of connectedness and recognition to people who have been displaced and traumatized by disaster.

SUMMARY:

This workshop will chronicle the evolution and accomplishments of the All Healers Mental Health Alliance (AHMHA). With initial support of the APA Office of Minority and National Affairs, this group of volunteer psychiatrists and other health professionals and advocates has organized to facilitate the delivery of mental health services to people affected by the 2005 Gulf Coast hurricanes. The group recognized that a majority of people displaced by the Hurricanes were members of underserved groups who experienced unmet mental health needs even before the disaster. In response, AHMHA has promoted: establishment of a network of culturally competent mental health practitioners; mental health screening through the use of the computerized tool QPD panel; case management utilizing cutting edge information technology; linkage with community gatekeepers including primary care, faith institutions, and Urban League satellites in cities affected by the Hurricanes; and training, consultation and support for caregivers using cutting edge interactive technologies. In addition, AHMHA has organized Heroes of Healing celebrations to provide connectedness to people dislocated by disaster and to honor people whose efforts have fostered the recovery and resilience of people affected by disaster and traumas. Legislative advocacy has played an important role in supporting the growth of AHMHA.

REFERENCES:

1. Dyson M: Come Hell or High Water: Hurricane Katrina and the Color of Disaster. Cambridge, MA, Perseus Books, 2006.
2. Shedler J, Beck A, Bensen D: Practical mental health assessment in primary care: Validity and utility of the Quick PsychoDiagnostics Panel. The Journal of Family Practice, July 2000, Vol. 49, No. 7.

Workshop 43 Saturday, October 13
3:30 p.m.-5:00 p.m.

ADDRESSING THE NEEDS OF COMMUNITY DWELLING OLDER PERSONS WHO HAVE BEEN DIAGNOSED WITH SCHIZOPHRENIA

National Institute of General Medical Sciences

Carl I. Cohen, M.D., *Professor of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Paul Ramirez, Ph.D., *Professor of Psychology, State University of New York, Health Sciences Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; John W. Kasckow, M.D., Ph.D.; Shilpa P. Diwan, M.D.; Azziza O. Bankole, M.D.; Pia N. Reyes, M.D.; Nikhil J. Palekar, M.D.; Mamta Sapra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Identify the multiple factors that can affect outcome in older adults with schizophrenia; and 2.) Recognize the need for cost-effective interventions that can be implemented without significant infrastructure requirements and that can positively affect psychiatric, physical, and social well-being in the older schizophrenia population.

SUMMARY:

It is estimated that the number of persons aged 55 and over with schizophrenia will double over the next two decades to over 1 million persons, and more than 85% of these persons will be living in community settings. Nevertheless, only 1% of the schizophrenia literature has been devoted to older adults, and treatment intervention research is especially sparse. There is a pressing need to identify points of intervention that will impact the care of these persons, and to develop cost-effective models that can be implemented to reduce morbidity and mortality associated with schizophrenia. In this workshop, we will present an overview of recent findings from our studies of older adults with schizophrenia in New York City. We will focus on various psychiatric, health, and social outcomes. First, we will review the interplay of psychoses, depression cognition,

adaptive functioning, and quality of life. Next, we will describe factors that influence the adequacy of health care in this population including our work on communication difficulties between psychiatrists and primary care physicians. Finally, we will examine factors that affect treatment adherence and clinical remission. Based on these presentations we will identify potential clinical and psychosocial intervention points, and we will explore with the participants, ideas for developing novel strategies for assisting this population.

REFERENCES:

1. Kommana S, Mansfield M, Penn DL; Disspelling the stigma of schizophrenia. Psychiatric Services (48) 1393–1395.
2. Phelan JC, Bromet EJ, Link BG; Schizophrenia and Psychiatric Illness in Older Adults. Schizophrenia Bulletin 1998 (24) 115–126.

Workshop 44 **Saturday, October 13**
3:30 p.m.-5:00 p.m.

IMPLEMENTING WELLNESS MANAGEMENT AND RECOVERY FOR CLIENTS IN SUPPORTIVE HOUSING

Marilyn Seide, Ph.D., *Division Chief, Los Angeles County Department of Mental Health, 7660 Beverly Boulevard, Suite 446, Los Angeles, CA 90036*; Suzanne Wagner, M.S., L.M.S.W.; Richard A. Miller, M.F.A.; Dorene Toutant, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should recognize and implement the concept of Wellness Self-Management in supportive housing settings.

SUMMARY:

As the impetus towards moving clients in mental health systems to less restricted, community-based, more permanent housing has gained acceptance and increased credibility as a desirable and necessary objective, the availability of such settings has greatly increased. The development of appropriate programs and services to assist persons with serious mental illness in maintaining themselves in the community has become a priority for those of us who are committed to assuring the viability, success and improved quality of life of these individuals. This workshop will discuss these concerns. Representative of organizations in the supportive housing community will discuss some new evidence-based practices which are being implemented that address the specific needs of mentally ill residents to assist them in such areas as developing skills and utilizing resources in order to achieve and maintain recovery and develop specific strategies for coping with persistent symptoms that lead to relapse. Presenters will discuss examples of using Wellness Self Management and other approaches in the supportive housing model.

REFERENCES:

1. Corp. for Supportive Housing: Developing the Supportive Housing Program. U.S. Dept. HUD, 2003.
2. Ford J., Young D., Obermyer R., Rohner D. Needs Assessment for Persons with Severe Mental Illness. Com. Mental Health Journal, 28(6), 1992.

Workshop 45 **Sunday, October 14**
10:00 a.m.-11:30 a.m.

PATHOLOGIC COMPUTER USE: PATIENTS WHO IMMERSE INTO VIRTUAL REALITY OR GAMES

American Association of Technology in Psychiatry

Jerald J. Block, M.D., *Adult Psychiatrist, Department of Psychiatry, Oregon Health Sciences University, 1314 N.W. Irving Street, Apt. 508, Portland, OR 97209-2725*; Sharon Packer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Discuss virtual worlds and computer gaming with their patients; 2.) Recognize the basic vocabulary used when discussing gaming; 3.) Assess pathological computer use; and 4.) List the functional and dysfunctional ways games and virtual reality are used.

SUMMARY:

Electronic games are everywhere. If you own a computer, TV, or cell phone, chances are someone is playing a game on them. And, it may not be the kids; the average gamer is around 30 years old. But, is it all fun and games? It is not unusual to meet people who game 40 or more hours a week. Is this healthy? While such questions are relevant, it is striking how few answers the psychiatric literature provides. Therapists' understanding of gaming lags far behind their patients' participation in it. Moreover, what information is getting to psychiatrists has often been shaped by sensationalized media reports. What should the therapist think about computer gaming and virtual reality? What are the benefits and risks and how certain is the data? It is time for us to start answering such questions. This workshop will bridge the ''culture gap'' between the gaming and clinical worlds. We will discuss virtual worlds and present a model by which to understand them. Using lecture, clinical case notes, game videos, and movie clips, we

will explore our patients' experience of the ''Virtual'' and the increasingly blurry boundaries between it and the ''real.'' Bring your own questions, examples, and observations!

REFERENCES:

1. Allison SE, von Wahlde L, Shockley T, Gabbard GO. The Development of the Self in the Era of the Internet and Role-Playing Fantasy Games. Am J Psychiatry, Mar 2006; 3: 381–385.
2. Block JJ. What in the (Virtual) World? Computer Gaming and Your Patients. MD Net Guide. September, 2005. http://www.mdnetguide.com/departments/2005-Sept/pc_block.htm.

Workshop 46 **Sunday, October 14 10:00 a.m.-11:30 a.m.**

THE THERAPEUTIC EFFECTS OF THE USE OF PHOTOGRAPHY IN MENTAL HEALTH

Jan Sitvast, M.A., R.N., *Nurse Specialist and Researcher, GGNet, Postbus 2003, Warnsveld, Netherlands 7230 GC*; Rene C.A. De Veen, M.D.; Anne Lenderink; Joost Baneke, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate and recognize how this intervention works in practive, what the main results are in terms of patient outcomes, and how the intervention is embedded in a care program.

SUMMARY:

This study investigates the photo-instrument: An intervention in mental health care using the medium of photography. The photo-instrument aims at providing meaningfulness to the experience of patients taking photos of their life world. It consists of sixteen group meetings. The participants receive a disposable camera and an assignment leading them to take photographs. Research is aimed at the subjective experiencing of (the consequences of) impairments and also at measuring positively labeled therapeutic effects of the photo-instrument: Patient empowerment and the enforcement of cognitions concerning acceptation of being ill. Methods. The self-image of the patient is the central issue in this research. This self-image is reflected in the photographs and the verbal expression of subjective experiences elicited by the therapists. Qualitative data show that self-esteem and self-efficacy increase, and the need for care decreases. The instrument was succesfully used in various therapeutic settings. Results in a treatment program for chronicaly ill patients will be described. It does so, we assume, by reducing a sense of shame and increasing a feeling of hope and trust in one's future. These effects are related to empowerment. Reconstruction of life stories is a powerfull therapeutic tool facilitating acceptation of illness.

REFERENCES:

1. Berman, H., Ford-Gilboe, M., Moutrey, B. & Cekic, S., 2001, Portraits of Pain and promise: a photographic Study of Bosnian Youth, in: Canadian Journal of Nursing research, vol. 32, no. 4, 21–42.
2. Hagedorn M., 1996, Photography: an aesthetico. Issues in Mental Health Nursing 1996; 17; 517–527.

Workshop 47 **Sunday, October 14 10:00 a.m.-11:30 a.m.**

CATCHING THEM BEING GOOD: SOCIAL LEARNING PRINCIPLES IN ACTION WITH CHILDREN

Maria De Pena-Nowak, M.D., *Assistant Professor of Psychiatry, New York Presbyterian Hospital, Payne Whitney Westchester, 21 Bloomingdale Road, White Plains, NY 10605*; Barbara-Ann Bybel, M.S., R.N.; Stella Jang, L.C.S.W.; Trecia Higgins, M.A.; Linda Espinosa, M.S., R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1.) Define the core components of Social Learning Principles applied to children in a psychiatric inpatient unit; and 2.) Recognize how this novel approach is an alternative to reduce coercive interventions.

SUMMARY:

Reducing seclusion, restraints and ''PRN'' medication poses a great challenge when, concurrently, length of stay is decreasing and acuity is rising. An interdisciplinary panel from Nichols Cottage, a 17 bed children's inpatient unit at New York Presbyterian Hospital/Payne Whitney Westchester, will present each discipline's perspective on their implementation of a Social Learning Program designed to modify individual and miliue treatment, as well as to effect a culture change on the unit. Expertise from senior hospital staff and faculty, including a team who successfully used this model with treatment refractory szhizophrenic adult patients, provided ongoing support and supervision. Social Learning principles have been studied more extensively in long stay, adult treatment programs and the panelists will outline how adaptations mindful of the developmental needs of children were devised. The new program aligns all activities and the structured daily schedule with pro-

social behaviors. It maximizes opportunities to positively interact with the children by "catching them being good". Shortly after implementing the new approach, the rates of seclusion and restraint began decreasing while patient and family satisfaction rates increased. This workshop will provide a forum for discussing how a treatment approach focused on pro-active reinforcement of positive behaviors can reduce coercive interventions.

REFERENCES:

1. Silverstein SM, Hatashita-Wong M, Wilkniss S, Bloch A: Behavioral Rehabilitation of the "Treatment-Refractory" Schizophrenia Patient: Conceptual Foundations, Interventions and Outcome data. Psychological Services 2006; Vol 3, No. 3, 145–9.
2. Donat DC: Encouraging Alternatives to Seclusion, Restraint, and Reliance on PRN Drugs in a Public Psychiatric Hospital. Psychiatric Services September 2005, Vol 56 No.9; 1105–1108

SYLLABUS INDEX

A

Abbasi, Farha Z. 89
Abma, T. 126
Abney, Mary Ann 14
Abramovitz, Robert H. 122
Abrams, Madeleine S. 153, 160
Achette, Daniela 76
Adams, Jr., Curtis N. 155
Adams, Neal H. 172
Adler, Karolyn 54
Adler, Lawrence W. 74
Agelink, Hans 167
Ahl, Jonna 67
Alao, Adekola O. 48, 79
Alarcon, Renato D. 52
Alderman, Jeffrey 37
Aldsworth, Cassandra 59
Alexander, Kim 46
Alexander, Marvin 125
Alexopoulos, George S. 92
Allen, Michael H. 36, 100
Altshuler, Lori L. 5
Alves-Bradford, Jean-Marie E. 172
Amador, Xavier 39
Amanbekova, Dinarra M. 55
Ammerman, Diane 96
Ana, Lucia Horta 94
Anaenugwu, Adaeze 75
Anagnostou, Evdokia 70
Ansari, Safeer A. 48
Aquila, Ralph 16
Arroyo, William 163, 169
Arvekvist, Robert 115
Ascher-Svanum, Haya 64, 65, 79
Ashbridge, Donna M. 12
Atkinson, A.R. 127
Awan, Huma 104
Ayub, Afshan 104
Azeem, Muhammad W. 104

B

Bailey, Rahn 8, 157
Bailey, Sue 171
Baker, Larry S. 130, 131, 138
Baker, Robert W. 64
Baker, Ross 38
Balis, Theodora G. 155
Ball, Daniel 79
Balluz, Lina 114
Baneke, Joost 175
Bankole, Azziza O. 31, 44, 45, 164, 171, 173
Baram, Vadim Y. 89
Barbosa, Leopolddo 76
Barnes, Donna 163
Barnes, Joy 50
Baroldi, Paolo 43, 90
Baron, Ann 153
Basu, Anirban 75
Batchelder, Sarai 100
Bates, Jay 90
Battaglia, Joseph 153, 160
Beal, Janice 167
Beeder, Ann B. 45
Bell, Carl C. 27
Bell, Ryan C. 162
Bell, Xyna 8
Bennington-Davis, Margaret ...125, 126
Berkowitz, Ellen 164, 171
Berlin, Jon S. 130
Berman, Robert M. 91, 97
Bhatia, Ajay 91
Bhatia, Subhash C. 55, 56
Biederman, Joseph .71, 92, 105, 108, 110
Bienvenu Jr., Oscar J. 121
Binsfeld, Gary 104
Bisbee, Cynthia C. 131
Bischoff, Natascha 72
Block, Jerald J. 174
Bose, Anjana 92, 93
Bossie, Cynthia A. 87, 98
Bowden, Charles L. 1
Bowers-Stephens, Cheryll 157
Boxus, Albert M. 31, 32
Bradford, Andrea C. 8
Bradshaw, Erica L. 20
Braga, Paula Ana 33, 93
Bright, George M. 105
Brixner, Diana 70
Brown, Nate 146
Bruscato, Wilze L. 33, 46, 76, 93, 94, 106
Brymer, Melissa 123
Buchanan, Silas 173
Buckley, Peter F. 3
Buckner, Ayanna V. 169
Buessing, Marique 116, 117
Bukstein, Oscar G. 60
Bulut, Mahmut 113
Bustamante-Avellaned, Victoria 109
Buuren, Michel Ten 167
Bybel, Barbara-Ann 175

C

Cabaj, Robert P. 159
Cain, Bernadette 19
Calderon, Jose 16
Calhoun, Patrick 20
Cameron, Rosie 77
Campbell, Jamae C. 47
Campbell, Nioaka N. 47
Canizales, Frank 121
Canuso, Carla M. 77, 98, 101
Carino, Anthony J. 162
Carlisle, Michael C. 51
Carlson, Harold E. 3
Carmel, Harold 78, 86
Carmona, Elodie 81
Caro, Jaime J. 99
Carpenter, Myrna 125
Carson Jr., William 91
Cerro, Lorri 74
Chang, Ilsung 68
Chang, Trina E. 128
Chapman, Daniel P. 78
Chen, Chi-Chang 95, 96
Chen, Lei 65
Chismar, Larissa 39, 47, 81
Cho, James 48
Choi, Juliet 121
Christensen, Richard C. 170
Chung, Catherine 48, 79
Clark, Clark 107
Clark, Trina 79
Cleton, Adriaan 68
Cline, Christie A. 147
Cohen, Carl I. 31, 44, 45, 173
Coldwell, Craig M. 80
Coley, Kim 96
Colihan, Christopher 17
Compton, Michael T. 34, 170
Conley, Robert 87
Conrad, Erich J. 16
Contractor, Laila F.M. 120, 125, 168
Cooke, Brian 34
Corey-Lisle, Patricia K. 97
Correll, Christoph U. 2, 4, 35
Costigan, Norman 61
Cote, Marie-Claude 114
Cournos, Francine 132, 141, 142
Courson, Vicki 52
Craft, Lynette 35
Csernansky, John G. 41
Cuffel, Brian 35, 69
Cullins, Lisa M. 124, 125
Cunningham, Jeanne 167
Curran, Geoff 83
Currier, Glenn W. 80

D

Davis, Lori L. 115
Deberdt, Walter G. 41
DeLand, Sarah M. 15
DeLeo-Kiernan, Deirdre' 158
DeMino, Kathleen A. 20
Demir, Sermet 55
Deneke, Ed 83
Dettwyler, Steven 49
Dewan, Mantosh 48
Dhopesh, Vasant P. 167
Diamond, Mary E. 120, 149
Diels, Joris 60
Dillon, Nancy 104
Dirani, Riad 103

Dirks, Bryan . . . 77, 98
Diwan, Shilpa P. . . . 31, 44, 45, 173
Dixon, Lisa . . . 34
D'Mello, Dale A. . . . 35, 107
Docherty, John P. . . . 87
Donahue, Jessica . . . 71, 92, 105
Douaihy, Antoine B. . 117, 133, 141, 142
Drake-McLin, Yvette . . . 156
Druss, Benjamin G. . . . 35
Dundas, Brian S. . . . 47
Dunn, Robert . . . 102
Dwyer, Martha . . . 18

E

Echenique, Marisa . . . 109
Edwards, Carla D. . . . 129
Edwards, Christopher L. . . . 146
Edwards, Natalie . . . 36
Eerdekens, Marielle . . . 64, 68
Ellen, Thelma . . . 143
Encrenaz, Gaelle . . . 81
Engel, Charles . . . 88
Engelhart, Luella . . . 36
Erder, M. Haim . . . 54, 92, 98, 116, 117
Escobar, Christian . . . 47, 81
Espinosa, Linda . . . 175
Eugene, Arnold L. . . . 95
Euler, Dillon C. . . . 171

F

Fabian, Tanya . . . 88
Fabian, Tanya J. . . . 96
Falcone, Tatiana A. . . . 155
Falk, Neil A. . . . 136
Faries, Douglas E. . . . 64, 65
Farkas, Gabriella Inczedy . . . 83
Farmer, John . . . 120
Fava, Maurizio . . . 62
Feirsen, Nicole . . . 70
Feldman, Jacqueline M. . . . 22, 157
Fernandez, Antony . . . 50
Fielding, Karen . . . 88
Findling, Robert L. . . . 60, 108, 110
Finister, Sheron . . . 161
Fisher, Dennis . . . 90
Fishkind, Avrim B. . . . 129, 130
Fisk, Deborah A. . . . 19, 20
Fitz-Gerald, Mary Jo . . . 50
Fitzgerald, Paul . . . 113
Fitzmorris, Tom . . . 29
Flynn, Laurie M. . . . 166
Folks, David . . . 72
Forgey, Marcy J. . . . 127, 128
Forstein, Marshall . . . 132, 140, 141, 142
Forte, Wilma . . . 106
Foti, Mary Ellen . . . 150
Frazer, Meg . . . 36
Frazier, Elizabeth . . . 115
Freeman, Elsie J. . . . 150
Fregonese, Adriana . . . 33, 46, 47, 76, 93, 94, 106
Fridman, Moshe . . . 54
Friedman, Catherine R. . . . 117
Fullilove, Mindy J. . . . 157

G

Gabalawi, Fayez El . . . 54
Gagne, Pierre . . . 114
Gallucci, Gerard . . . 49
Gandelman, Kuan . . . 37
Gandhi, Chetan . . . 92, 93
Ganguli, Rohan . . . 96
Garakani, Amir . . . 62
Garces, Lorrie K. . . . 170
Garcia, Manuel . . . 35
Garcia, Manuel E. . . . 37
Garrett, Michael D. . . . 27, 164
Gehring, Lorrin . . . 125
Gergerlioglu, Hasan . . . 113
Gharabawi, Georges M. . . . 77
Ghate, Sameer . . . 70
Ghinassi, Frank . . . 88
Gibbs, Gerry . . . 165
Girdano, Suzanne . . . 35
Glass, Jennifer R. . . . 99
Glick, Rachel L. . . . 129
Goalder, James . . . 18, 20
Goldberg, Richard . . . 34
Goldfinger, Stephen M. . . . 164, 171
Goldfischer, Evan R. . . . 69
Goldman, Howard H. . . . 25
Goldstein, Harold . . . 133
Goldstein, Sarah . . . 158
Gommoll, Carl . . . 93
Goncalves, Antonio . . . 76
Gonzalez, Jodi M. . . . 5
Goulding, Sandra . . . 37
Graber, Cheryl . . . 38, 52, 82, 85
Grandfield, Sylvia . . . 80
Greenbaum, Michael . . . 108
Greenberg, Paul . . . 116, 117
Greene, Paul . . . 97
Gruttadaro, Darcy . . . 166
Gutierrez, Meghan . . . 166
Guzofski, Sarah C. . . . 162

H

Hackman, Ann L. . . . 34, 137, 155
Hair, Kelly C. . . . 86
Hall, Lacresha L. . . . 172
Halliday, Basil D. . . . 145
Halpern, Danielle . . . 70
Hamilton, Jennifer . . . 99
Hamilton, Tom . . . 163, 169
Hampson, Michele . . . 75
Hancock, Laura G. . . . 47
Hanson, Carl D. . . . 83
Harding, Richard . . . 118
Harnett, James . . . 69
Harris, Toi B. . . . 136, 142, 160
Harrison-Ross, Phyllis . . . 169, 171, 173
Haskett, Roger F. . . . 88
Haupt, Daniel . . . 38
Hayes, Larry . . . 157, 159
Hays, Erin M. . . . 46
Head-Dunham, Rochelle . . . 25, 159
Heath, Jennifer E. . . . 47
Hekkink, Yvonne . . . 127, 167
Hellerstein, David J. . . . 100
Hellstrom, Wayne . . . 30
Henderson, Elizabeth C. . . . 9, 157
Herman, Barry K. . . . 100
Heru, Alison M. . . . 168
Hierholzer, Robert W. . . . 108
Higgins, Jr., Napoleon B. . . . 8, 172
Higgins, Trecia . . . 175
Hill, Elliott . . . 13, 139, 159, 167
Hilliman, Charlyn A. . . . 171
Ho, Andrew P. . . . 111
Hoed, Johanna Van Den . . . 167
Hoek, Paul van . . . 68
Hoekstra, T. . . . 126
Hoge, Charles . . . 88
Houston, John P. . . . 67
Huffine, Charles W. . . . 124
Huffine, Jr., Charles W. . . . 124
Hunt, Justin B. . . . 83, 161
Hunter, Robert . . . 77
Hunter, Robert M. . . . 77
Husain, Mustafa . . . 113
Husain, S. Arshad . . . 134
Hussey, James H. . . . 23
Hutton, Charlotte N. . . . 160
Hyler, Steven E. . . . 100
Hypolite, Iman O. . . . 157

I

Iancia, Joseph . . . 10
Illa, Lourdes T. . . . 109
Iqbal, Javed . . . 104
Ishak, Jack K. . . . 99
Ivory, Jennifer R. . . . 86

J

Jackson, Mae . . . 173
Jacobs, Anne . . . 123
Jang, Stella . . . 175
Janicak, Philip G. . . . 101
Janseen, M.G.M. . . . 127
Janssen, Wim . . . 126
Jauch, John . . . 61
Jewell, Peggy H. . . . 150
Johnson, C. Philip . . . 14
Johnson, Dale L. . . . 132
Johnson, Janet . . . 84
Johnson, Peggy L. . . . 59
Jones, Cheryl W. . . . 50
Jones, Makeda N. . . . 160
Jones, Robert B. . . . 104

Jutand, Marthe-Aline 81
Juthani, Nalini V. 26

K

Kadalar, Sheela 154
Kalai, Amir 77
Kambampati, Vikram 51
Kan, Hongjun 95
Kane, John M. 4, 28, 39
Kanofsky, J. Daniel 39, 47, 81
Kasckow, John W. 173
Kast, Richard E. 91
Kavanagh, Sarah 77
Kayne, Jon 55
Keefe, Richard 41
Kelly, Shirley 43
Kepler, Andrea 11
Kerney, Donna 39
Ketter, Terence A. 102
Khadavi, A.N. 126
Khadivi, Ali 56
Khan, Arif 92
Khan, Arif M. 91
Khawaja, Imran 104
Kidwell, Betsy 120
Kim, Edward 38, 90, 95, 96
Kim, Jane 109
Kim, Myoung 96
Kim, Thomas J. 171
Kimbrough-Melton, Robin J. 144
Kinon, Bruce J. 64, 65, 79
Kinrys, Gustavo D. 102
Kinzie, J. David 29
Kioroglo, Paula 46
Kirk-Lee, Wilma 142
Knapp, Rebecca 110
Knight-Richardson, Norwood 171
Kollack-Walker, Sara 65
Kosik-Gonzalez, Colette 77
Kotwicki, Raymond J. 170
Kovacic, Karen 42
Kovess-Masfety, Viviane 81
Kozma, Christopher M. 103
Kravos, Matej 84
Krishnan, Suma 108, 110
Kua, Stephanie 59
Kudler, Harold S. 162
Kujawa, Mary J. 39, 87, 103
Kung, Simon 51, 52
Kuprevich, Carol 112
Kwentus, Joseph 42

L

Laitman, Leila B. 158
Lam, Annette 60, 61, 66
Lamb, H. Richard 170
Landgraf, Jeanne 95
Landron, Frederic 85
Landwehr, Karen A. . 130, 131, 137, 138
Lane, Rosanne 64
Lapid, Maria I. 51, 111
Lawrence, Leslie E. 84
Lawson, William B. 163
Layne, Christopher 123
Lazarus, Arthur L. 74
LeDay, Angela 60
Lee, Catie 104
Lee, Eugene 157, 168
Lee, James E. 165
Lee, Pastor W.S. 143
Lefley, Harriet P. 131
Lehert, Philippe 62, 85
Lehmann, Laurent S. 162
Lendemeijer, Bert 126
Lenderink, Anne 175
Leon, Ovidio A. De 97
Lesage, Alain D. 10
Levounis, Petros 166
Li, Dayong 93
Ligate, Loys 61
Lim, Pilar 64
Lim, Russell F. 165
Lima, Maria das Gracas 47
Lindy, David C. 153, 158
Lineberry, Timothy W. 51
Linehan, Kathleen 61
Lipkovich, Ilya 41, 67
Lisanby, Sarah H. 113
L'Italien, Gilbert 97
Loebel, Antony D. 35, 36, 49, 69, 72, 100, 102
Loebl, Adi 160
Lombardo, Ilise D. 37, 72
Lopez, Cardoza 123
Lopez, Frank 60
Lott, Ira 67
Lozano, Cosme O. 61
Lu, Francis G. 154, 159
Lu, Mary W. 40
Lucey, Jeff 153, 160
Luong, Doanh 99
Lyne, Andrew 71, 92, 105

M

Maass-Robinson, Sandra A. 157
Macaluso, Matthew 38, 52, 82, 85
MacFadden, Wayne 103
Magill, John 118
Magruder, Kathryn 110
Mahaffey, Kirsten 61
Mahmoud, Ramy 39, 77, 98
Malamud, Thomas A. 16
Malerbi, Fani 47
Malesic, Ivan 84
Malla, Ashok K. 49
Mallios, Ronna 108
Mallya, Anita 38, 82
Mamamtavarishvili, Maia 39, 47, 81
Mandel, Francine 100
Mangurian, Christina V. 156
Mao, Lian 101, 103
Marcus, Ronald N. 91
Marcus, Sue 62
Marder, Stephen R. 87
Martin, Elisabeth 107
Martinez, Anthony 46
Martinez, Jose 62
Mason, Barbara 62
Mason, Fiona 55
Mattox, Rhonda J. 86
May, Catherine S. 9
Mayers, Terry 159
McBurnett, Keith 92, 105
McCabe, Bhrett 91
McCall, W. Vaughn 113
McCarron, Robert M. 165
McCutcheon, Edna 11, 12
McFarland, Bentson 40
McFarlane, William R. 24
McGee, Tanya 147
McGough, James J. 71
McKay, Micheal 95
McLeod-Bryant, Stephen A. 154
McManus, Michael 110
McQuade, Robert D. 91, 97
McQuistion, Hunter L. 136
McSweeney, Jean 86
McVoy, Molly K. 161
McVoy, Peter 161
Mee-Lee, David 151
Meletiche, Dennis M. 36
Mellacheruvu, Sandeep 63
Melmed, Raun 92
Melton, Gary B. 144
Melton, Ryan 40
Meltzer, David 75
Meltzer, Herbert Y. 75
Mermelstein, Hindi 53
Messiah, Antoine 81
Metoyer, Paul 167
Metzner, Richard J. 111
Miceli, Mark 82
Mikl, Jaromir 69
Miller, Del 3
Miller, Elissa 164
Miller, Michael 63
Miller, Richard A. 174
Minehart, Margaret A. 119
Minkoff, Kenneth M. 146, 147, 150, 151
Mishkin, Adrienne 84
Mokdad, Ali 114
Mokwa, Chief Joseph 137
Moller, Mary 17, 154
Mollica, Richard F. 123
Molnar, Margaret 18
Montgomery, William 65
Moore, Christine 97
Moore, Richelle 63
Morales, Alexander Rodriquez 60
Mucha, Lisa 69
Murphy, Sharon 116

Murphy, Tim ... 126
Mussa, Claudia ... 47

N

Najarian, Dean ... 39, 64
Nakanishi, Dennis ... 61
Narasimhan, Meera ... 118
Natarajan, Jaya ... 68
Nelson, Laura K. ... 150
Nery, Fernanda ... 102
Newcomer, John W. ... 22, 49
Newkirk, Cassandra F. ... 163, 165, 170
Ng, Anthony T. ... 136
Nguyen, Charles S. ... 40
Nicholl, Jeffrey S. ... 30
Nieves, Jose E. ... 15, 53
Nipper, Darlene ... 145
Nitsche, Allison M. ... 8, 162
Nnawuchi, Ikechi C. ... 130
Noether, Chanson D. ... 163
Nogueira-Martins, Luis ... 94
Noorthoorn, Eric ... 126
Norquist, Grayson S. ... 134
Norrie, John ... 77
North, Carol S. ... 22
Norton, John ... 63
Nossel, Ilana R. ... 128
Nyhuis, Allen W. ... 64, 79

O

Oestricht, George ... 86
Olarte, Silvia W. ... 28
Olivares, Jose ... 60
Onate, John C. ... 165
Osher, Fred C. ... 163, 169
Osipyan, Vera ... 55
Osofsky, Howard J. ... 123, 134, 144
Osofsky, Joy ... 123, 144
O'Sullivan, MacDara ... 153

P

Packer, Sharon ... 174
Palaniyappan, Lena K. ... 58
Palekar, Nikhil J. ... 45, 173
Palumbo, Joseph M. ... 64
Panzer, Paula G. ... 123
Parks, Joseph J. ... 11, 78, 86, 148, 149
Patel, Anil S. ... 92, 105
Patel, Chintan ... 40, 64, 65
Patel, R.C. ... 126
Paulino-Wooldrige, Johanna F. ... 159
Paulsson, Bjorn ... 115
Pecenak, Jan ... 66
Peele, Roger ... 153
Pena-Nowak, Maria De ... 175
Perez, Lucy ... 173
Perlis, Roy H. ... 1
Perret, Nancy Burris ... 140
Perry, Geraldine ... 78
Peso, Jacqueline ... 36
Pessin, Neil ... 153, 158
Pharm.D., Gary L. Ellenor, ... 49
Piderman, Katherine ... 111
Piezer, Kevin ... 67
Plon, Lawrence ... 67
Poelert, Hans ... 126
Pollack, Stacey ... 162
Pollock, Ralph C. ... 47
Ponce, Allison N. ... 7, 19
Pouncey, Claire L. ... 54
Povey, Michael ... 61, 66
Preskorn, Sheldon H. ... 37
Prier, Ronald ... 118
Primm, Annelle B. ... 120, 135, 145, 154, 169, 171
Priyankar, Sarkar ... 41
Prosser, John ... 68
Pumariega, Andres J. ... 121
Pyke, Robert ... 69
Pynoos, Robert S. ... 123

Q

Quitangon, Gertie D. ... 55

R

Radke, Alan Q. ... 7, 148, 150
Rado, Jeffrey T. ... 165
Rafael, B. ... 123
Rahal, Sabrina ... 106
Raley, Jesse A. ... 47
Ramakrishnan, Parameshwaran ... 55, 56
Ramaswamy, Sriram ... 55, 56
Rami, Falu ... 161
Ramirez, Paul ... 173
Ramirez, Paul M. ... 44, 45
Randall, Terri L. ... 168
Rao, Aruna S. ... 172
Rasgon, Natalie L. ... 73
Razavi, Maryam A. ... 154
Real, Lawrence A. ... 54
Reid, Nicole A. ... 56
Reist, Christopher ... 69
Renaud, Johanne ... 10
Renner, John A. ... 166
Reyes, Pia N. ... 31, 44, 45, 173
Ribeiro, Fernando ... 106
Richardson, Karen ... 42
Rickels, Karl ... 62
Riordan, Henry ... 97
Rivelli, Sarah K. ... 165
Rizkallah, Jihad ... 69
Roberts, Holly ... 102
Robinowitz, Carolyn B. ... 154
Robinson, Jacquelyn A. ... 140
Robinson, Rebecca ... 110
Rodrigues, Rosana ... 94
Rodriquez, Allan ... 109
Rodriquez, Stephen ... 87, 103
Romeo, Fabio ... 101
Romine, Ann ... 63
Ronis, Robert J. ... 170
Rosen, Alan ... 157
Rosenblatt, Lisa ... 38, 70
Rosenquist, Peter ... 113
Roskes, Erik J. ... 163, 170
Rossenu, Stefaan ... 68
Rossi, Alessandro ... 101
Rothstein, Ethan ... 102
Rotter, Merrill R. ... 56
Rouse, Jeffrey C. ... 163
Roy, Vicki ... 36
Rudd, Butterfly ... 118
Rummans, Teresa A. ... 111
Runnels, Patrick S. ... 164
Rusoff, Jade ... 70
Rutledge, Lindsey D. ... 153
Ruzek, Josef ... 123
Ryan, Susan ... 111

S

Sabbe, Bernard ... 41
Sachs, Paul ... 119
Said, Qayyim ... 70
Saint-Jean, Gilbert ... 109
Sakely, Kristen ... 88
Salary, Cheryl Y. ... 157
Sale, Tamara ... 40
Salem, Anasuya ... 112
Sallee, Floyd R. ... 71
Samples, Carl ... 20
Sanchez-Martinez, Mario J. ... 109
Sanders, Pastor Torin ... 143
Sandman, Curt ... 67
Sapinho, David ... 81
Sapra, Mamta ... 31, 44, 173
Sargent, John ... 168
Sassi, Roberto B. ... 102
Sattar, S. Pirzada ... 112
Sauer, Heinrich ... 72
Savas, Haluk A. ... 113
Scheifler, Patricia L. ... 131
Schneider, Eugene J. ... 62
Schneider, Matthew R. ... 57
Schnurr, Paula ... 88
Scholer, Robert ... 16
Schooler, Nina R. ... 26
Schreiner, Andreas ... 98
Schultz, Charles S. ... 63
Schweinfurth, John ... 63
Sciarretta, Antonio ... 101
Scott-Gurnell, Kathy ... 8, 160
Sedek, Greg ... 99
Seide, Marilyn ... 174
Selek, Salih ... 113
Sequin, Monique ... 10
Sessa, Robert ... 46
Shah, Chandresh ... 57
Shah, Saranga ... 85
Sharma, Ajay ... 42
Sharma, Sonali ... 128
Shenoy, Akhil ... 58

Shern, David 166
Sherr, Jay 36
Shervington, Denese 165
Shi, Lizheng 65
Shlakman, Samantha A. 154
Shuster, Adriana E. 160
Simon, Liz 159
Simons, W. Robert 90
Simonson, R. Bruce 39
Simpson, Sherri M. 160
Sinaii, Ninet 88
Singer, Patricia 149
Singh, Gagandeep R. 85
Singh, Raj 52
Siskind, Dan J. 58, 87, 109
Sitvast, Jan 175
Siu, Cynthia 35, 49
Smith, Gregory M. 12
Smith, Jacqueline 148
Smith, Jim 72
Smuckler, Daniel J. 153
Sobanski, Thomas 72
Sofianos, Georgios 72
Solhkhah, Ramon 168
Solvason, Brent 113
Somers, Kristin J. 111
Song, Sue 63
Soorya, Latha 70
Sowers, Wesley E. 152, 158, 172
Srinivasan, Shilpa 118
Stack, Kathleen M. 18, 20
Stahl, Stephen M. 49
Stauffer, Virginia 65
Steinberg, Alan L. 123
Stern, David A. 160
Stevens, Susanna 52, 111
Stewart, Altha J. 24, 154
Stolar, Andrea G. 51
Stovall, Jeffrey G. 17, 135
Stowell, Keith R. 88
Straube, Eckart 72
Strine, Tara W. 78, 114
Strunin, Lee 59
Stuve, Paul 86
Styron, Thomas H. 7, 19
Subramanian, Purushothaman 58
Subramanian, Senthil A. 58
Suite, Darcel 173
Suite, Derek H. 157
Sullivan, Greer 83
Sullivan, J. Greer 86
Sutherland, Secrest 50
Svendsen, Dale P. 149
Swanink, Rene 91, 97

T

Tan, Violeta 73
Tan, Ye 99
Terhakopian, Artin 88
Thomas, Richard 14
Thompson, Ann 36
Thompson, John 15
Thompson, Kenneth S. 156
Tiradritti, Paola 101
Tobia, Anthony M. 38, 52, 82, 85
Tomori, Oladapo T. 79
Ton, Hendry 120
Torres, Michael A. 142
Torres, Rosarelis 73
Touchette, Paul 67
Tourkodimitris, Stavros 85
Tournay, Anne 67
Toutant, Dorene 174
Townsend, Mark H. 13, 16, 159
Tran, Quynh-Van 96
Trangle, Michael A. 156
Trottier-Hebert, Valerie 114
Turecki, Gustavo 10
Turkoz, Ibrahim 98
Turnbow, John 60

U

Uezato, Akihito 115

V

Vaghela, Kuldeep 51
Vahia, Ipsit V. 31, 44, 45
Vallow, Susan M. 103
Vandebosch, An 68
Vanega, Lorraine 56
Vasconcelos, Debora de Sa 102
Veach, Jeff 78
Veen, Rene C.A. De . 125, 126, 167, 175
Verna, Marie 18
Versavel, Mark 37
Vickar, Garry M. 137, 138
Viron, Mark J. 84
Vita, Antonio 101
Vliet, Iris van de 68
Vogel-Scibilia, Suzanne E. 23
Volkman, Edward A. 119
Vrable, Mathew 51
Vruwink, Fleur 126
Vu, Holly 108

W

Wagner, Gerd 72
Wagner, Suzanne 174
Wainberg, Milton L. 133
Walker, Jill Kerrick 101
Walsh, David 67
Wang, Cheng 98
Wang, Philip S. 135
Wapenyi, Khakasa H. 133
Warrington, Lewis 49
Warrington, Lewis E. 102
Wasserman, Stacey 70
Watsky, Eric 49
Weaver, James 62
Webster, Steven L. 43
Weiden, Peter 49
Weiden, Peter J. 43
Weinstein, Henry C. 163, 169
Weisler, Richard H. 74, 115
Weisser, Lydia E. 8
Welsh, Christopher J. 166
Westray, Henry 163
White, Andrew W. 59
Whitecraft, Jeanie 120
Whitehead, Richard ... 38, 70, 90, 95, 96
Widdershoven, Guy 126
Wigal, Timothy 71
Wijk, Cecilia Gijsbers van 82
Wiley-Exley, Elizabeth 87
Williams, Eric R. 172
Williams, Jill 18, 19
Williams, Mark 50
Williams-Ortega, Sandra 139, 161
Willis, Diane J. 143, 145
Wills, Cheryl D. 165
Winstead, Nathaniel S. 30
Witte, George 157
Woesner, Mary E. 39, 47, 81
Wolf, Robert M. 40
Wolfgang, Curt 43, 73, 90, 99
Woo, Benjamin K.P. 59
Woodard, Martin 160
Woodruff, Douglas 116
Wortham, Roger L. 121
Wu, Eric 116, 117
Wu, Jasmanda 101
Wylie-Rosett, Judith 39, 47, 81

X

Xiong, Glen 165

Y

Yang, Elaine 116, 117
Yang, Ruoyong 72
Yilmaz, Haci 113
Yu, Van 171
Yu, Yanni 95

Z

Zani, Brigid 40
Zeller, Scott L. 130
Zepp, Henri 74
Zhang, Yuxin 108, 110
Zhao, Zhongyun 60
Zhu, Baojin 65

60th Institute on Psychiatric Services

October 2–5, 2008

The American Psychiatric Association's leading educational conference on clinical issues and community mental health to meet the service needs of people with severe mental illness.

From Patient to Partner: Transforming Systems of Care

This four-day event will feature more than 100 exhibits that complement the educational program, popular networking events, and over 200 expertly-led educational sessions on topics including: Violence, Trauma, and Victimization; Social and Community Psychiatry; Psychopharmacology; Resident and Medical Student Concerns; Disorders; Cross-Cultural and Minority Issues; Psychiatric Administration and Services; Treatment Techniques and Outcome Studies; Cognitive Disorders; Health Service Research; Mood Disorders; Schizophrenia and Other Psychotic Disorders; and much more…

Who Should Attend?

- All APA Members
- Psychiatrists and mental health professionals in community practice or the public sector including state and Veterans Affairs hospitals, community clinics, and jails and prisons
- Psychiatric Administrators
- Mental health professionals interested in social issues that have an impact on patients and their families
- Minority psychiatrists and International Medical Graduates
- Psychiatric Residents (only $60 for advance registration)
- Nonmember Residents and Advocacy Group Members (only $85 for advance registration)
- Medical Students (free registration)

Why Should You Attend?

- This activity has been approved for AMA PRA category 1 credit and CEU credit
- Receive a 40% discount on APA member registration fees
- Network with colleagues at receptions and other events
- Industry-supported lunch and dinner symposia
- Valuable exhibit hall prizes drawn each day

How Will You Benefit?

- Learn about the latest updates and acquire new skills in clinical psychiatry, that can be utilized to improve patient care;
- Acquire a deeper understanding of how the current health care system affects patient care;
- Demonstrate and apply new skills useful in clinical and public psyngs; try settings;
- Recognize and improve mental health disparities in the community; and
- Describe how to transform systems of care.

Preliminary Program:

The Preliminary Program, which includes registration, housing, and travel information will be available in May at www.psych.org/IPS2008 or call 1-888-35-PSYCH and request a copy. Online registration will begin on June 3.

For more information, please contact:
American Psychiatric Association
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901
Phone: 1-888-35-PSYCH or
(703) 907-7300
Fax: (703) 907-1090
E-mail: apa@psych.org
Web: www.psych.org/IPS2008