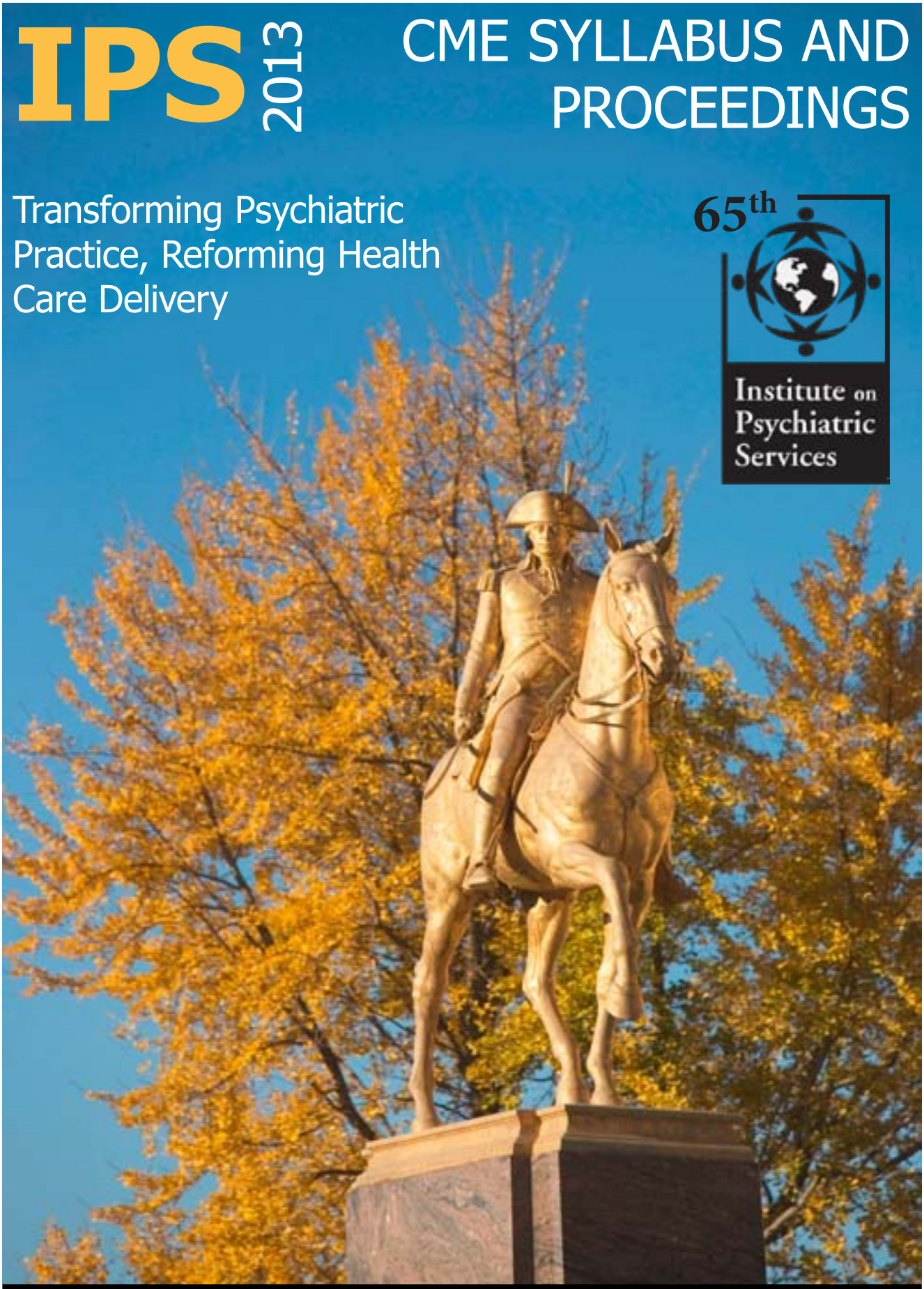
IPS 2013

CME SYLLABUS AND PROCEEDINGS

Transforming Psychiatric Practice, Reforming Health Care Delivery

65th Institute on Psychiatric Services



American Psychiatric Association • Philadelphia, October 10-13

Contents

COURSES AND SEMINARS

FRIDAY, OCTOBER 11, 2013

SEMINAR 01

THE IMG JOURNEY TO AN AMERICAN PSYCHIATRIC CAREER: ROADMAP FOR SUCCESS

Directors: Nyapati R. Rao, M.D., M.S.; Jacob Sperber, M.D.

Faculty: Mantosh Dewan, M.D.; Andrés F. Sciolla, M.D.; Rashi Aggarwal, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Name 3 strategic ways IMG psychiatric residents can overcome educational challenges related to educational immigration; 2)Identify in themselves instances of automatic (unconscious) social categorization (stereotyping), and relate those to their cultural upbringing and their acculturation process in the US; and, 3) Identify potential solutions to challenges faced by women IMG's.

SUMMARY:
Internationally-trained psychiatrists make up a third of the American psychiatry workforce, and an even larger fraction of the psychiatrists who care for the disadvantaged and underserved. The cultural diversity of this International Medical Graduate (IMG) group brings unique strengths to their care for the increasingly globalized patient population but also carries certain challenges to the IMG practitioner's training and integration into the US healthcare system, challenges for which specific orientation and strategies can be very helpful. In this seminar, faculty members, all educational leaders of programs where IMG psychiatrists have successfully trained, will guide the attendees through orientation and discussion of key topics for aspiring international psychiatrists joining the US healthcare system: the rapidly-changing system dynamics of the US healthcare system; the roles of IMGs in the US psychiatric workforce; specific controversies in US psychiatry that IMGs need to master; specific challenges for women IMGs; coming to grips with prejudice and discrimination in the US and its healthcare system; and specific challenges for stages of career development in US psychiatry. The seminar welcomes both aspiring trainees and experienced clinicians who are themselves on the IMG journey along American careers, and also those who are involved in their education.

SEMINAR 02

BUPRENORPHINE AND OFFICE-BASED TREATMENT OF OPIOID DEPENDENCE

Director: John A. Renner Jr, M.D.

Faculty: Petros Levounis, M.A., M.D., Laura F. McNicholas, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the clinically relevant pharmacological characteristics of buprenorphine; 2) Describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence; 3) List three factors to consider in determining if the patient is an appropriate candidate for office based treatment with buprenorphine.

SUMMARY:
The purpose of the course is to provide information and training to participants interested in learning about the treatment of opioid dependence, and in particular physicians who wish to provide office based prescribing of the medication buprenorphine for the treatment of opioid dependence. Federal legislative changes allow office based treatment for opioid dependence with certain approved medications, and Food and Drug Administration (FDA) approved buprenorphine for this indication. The legislation requires a minimum of eight hours training such as the proposed course. After successfully completing the course, participants will have fulfilled the necessary training requirement and can qualify for application to utilize buprenorphine in office-based treatment of opioid dependence. Content of this course will include general aspects of opioid pharmacology, and specific aspects of the pharmacological characteristics of buprenorphine and its use for opioid dependence treatment. In addition, other areas pertinent to office based treatment of opioid dependence will be included in the course (e.g., non-pharmacological treatments for substance abuse disorders, different levels of treatment services, confidentiality). Finally, the course will utilize case-based, small group discussions to illustrate and elaborate upon points brought up in didactic presentations.

COURSE 01

UPDATE ON PSYCHOPHARMACOLOGY

Director: Dwight L. Evans, M.D.

Faculty: Steven E Arnold, M.D.; C. Neill Epperson M.D.; Michael E. Thase, M.D.; Lazlo Gyulai, M.D.; Mahendra T. Bhati, M.D.; Anthony Rostain, M.D.; Steven Siegel, M.D., PhD

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants should be able to: 1) Provide an update on recent advances in psychopharmacology of major disorders; 2) Demonstrate knowledge of practical clinical use of psychopharmacology and management of adverse events; 3) Demonstrate knowledge of recent research on pharmacotherapy in common psychi-

atric disorders; 4) Provide a rational basis for selection of medications for bipolar disorder, schizophrenia, and other psychotic disorders; and, 5) Discuss efficacy and side effects of antipsychotic agents.

ABSTRACT:
Psychopharmacology remains a mainstay of psychiatric treatment. The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in their practices. This Course will provide an update and discussion of recent data in psychopharmacology, as well as review recent advances in the treatment of a number of common disorders.

This course is designed for practitioners of intermediate and advanced skill levels.

COURSE 02

CURRENT PROCEDURAL TERMINOLOGY CODING AND DOCUMENTATIO

Director: Allan A. Anderson, M.D.; Chester Schmidt, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) understand the use of the new psychiatric evaluation and therapy codes that went into effect in 2013;2) Understand as well as the traditional codes in the Psychiatry section of CPT; and 3) understand the evaluation and management codes that are an essential element of the new coding framework.

SUMMARY:
The Current Procedure Terminology (CPT) codes used by psychiatrists have undergone major changes in 2013. This course will familiarize attendees with these new codes and how to document for them, as well as providing them with

information about the remaining codes in the Psychiatry section of CPT, and the codes in the Evaluation and Management section of CPT, which are critical to psychiatrists under the coding framework put in place for 2013. The course is for clinicians (psychiatrists, psychologists, and social workers)and their office personnel who may assist them with coding and billing. Course attendees are encouraged to obtain the AMA's 2013 CPT Manual (CPT codes are developed and copyrighted by the AMA) and read the following : 1) the Guideline Section for the Evaluation and Management codes; 2) the Evaluation and Management Codes themselves; and 3) the section on "Psychiatric Evaluation and Therapeutic Procedures." The objectives of the course are two-fold: first, to familiarize attendees with all the new CPT coding framework that went into effect in 2013 and all the codes that are now being used by mental health clinicians and to review issues and problems associated with payer-imposed barriers to payment for services denoted by these codes; and second, attendees will review the current AMA/CMS guidelines for documenting the services/procedures provided to their patients. Templates for recording evaluation and management services, initial evaluations, and psychotherapy services will be used to instruct the attendees in efficient methods of recording data to support their choice of CPT codes and the level of service provided.

SEMINAR 03

IMPACT OF PSYCHIATRIC DISORDERS ON HIV CARE AND TREATMENT

Director: Dube Benoit, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand current epidemiological trends in the HIV epidemic; 2) Understand the diagnostic and treatment approaches to neuropsychiatric disorders in people with HIV/AIDS; 3) Discuss strategies for effectively working with psychiatrically complex patients.

SUMMARY:
Advances in the treatment of the human immunodeficiency virus (HIV) have dramatically improved survival rates over the past 10 years. As life expectancy increases, those who arc infected also age and become vulnerable to other medical and psychiatric co-morbid disorders. In addition, new infections are occurring in the over 50 population as well, thus more and more clinicians are likely to encounter HIV-related psychiatric and neuropsychiatric complications associated with the patient's illness. Some patients can present with a spectrum of psychiatric disorders during the course of HIV, while others may experience cognitive deficits due to an HIV-triggered neurotoxic cascade in the central nervous system. Such disorders can adversely influence the progression of HIV disease; complicate assessment and diagnosis; impact engagement in care and adherence to medication therapy; and, if missed, can lead to irreversible damage. As quality of life becomes a more central consideration in the management of HIV as a chronic illness, better awareness of these disorders is paramount. During this session faculty will use both a didactic and case-based approach for reviewing the assessment, diagnosis and treatment of the psychiatric and neuropsychiatric disorders. Clinicians at all stages of experience will find this training to be a valuable for understanding and responding to the complex clinical dilemmas often encountered with HIV patients. The session will be divided into two parts. Part I will review the clinical changes seen in the epidemic; provide an update on common psychiatric disorders seen in patients with HIV with an emphasis on depression and substance use disorders; working with difficult patients; and an overview of cognitive disorders. Part II will review the

benefits of an integrated, multidisciplinary approach to care and feature case discussions. Attendees are invited to bring their own cases for discussion in a round-table setting. The session will conclude with practical approaches to topics raised in the roundtable groups.

SEMINAR 04

CULTURALLY APPROPRIATE ASSESSMENT REVEALED: THE DSM-IV-TR OUTLINE FOR CULTURAL FORMULATION INTERVIEWS

Directors: Russell F. Lim, M.D.; Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe interviewing techniques to assess the various aspects of cultural identity; 2) Describe methods to elicit the cultural explanation of the individual illness or explanatory model; 4) Discuss and identify ethncocultural transference and countertransference; 5) Describe how to formulate a case with the differential diagnosis and how to negotiate a treatment plan with a patient.

SUMMARY:
Being able to perform a culturally appropriate assessment is a skill required by current RRC Accreditation Standards, including the ACGME core competencies for all graduating psychiatric residents. In addition, the Institute of Medicine's (IOM) report, "Unequal Treatment," showed that patients belonging to minority populations received a lower level of care than mainstream patients, when matched for socioeconomic status. A culturally appropriate assessment can reduce mental health disparities by improving the quality of care provided to minority and underserved groups, improving their engagement, diagnosis, and treatment outcomes.

There are many tools that can be used for a culturally appropriate assessment, such as the OCF, the Cultural Formulation Interview (CFI) from DSM-V, and various mnemonics. The DSM-IV-TR Outline for Cultural Formulation (OCF) is an excellent tool for the assessment of culturally diverse individuals, as is the Cultural Formulation Interview. Both provide a framework to assess cultural identity, explanatory models, stressors and supports, the clinician-patient relationship, and overall cultural formulation. The course will also present Hay's ADDRESSING framework for assessing cultural identity, Arthur Kleinman's eight questions to elicit an explanatory model, and the LEARN model used to negotiate treatment with patients. Attendees of the course will learn how to assess their own and their patient's cultural identities, and how the ethnicity and culture of the clinician and patient affects transference and counter transference.

The course will teach clinicians specific skills for the assessment of culturally diverse patients. Participants will participate a small group exercise on their own cultural identities, and then will view mini lectures on the five parts of the DSM-IV-TR Outline for Cultural Formulation, as well as instruction on interview skills, supplemented by the viewing of taped case examples. Discussion of the case vignettes will enable attendees to gain an understanding of the skills demonstrated in the videotaped vignettes. Participants will be encouraged to share their own approaches, and then modify their approaches based on material presented in the course. Clinicians completing this course will have learned interviewing skills useful in the culturally appropriate assessment, differential diagnosis, and treatment planning of culturally diverse patients.

SATURDAY, OCTOBER 12, 2013

SEMINAR 05

THE INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH: PRACTICAL SKILLS FOR THE CONSULTING PSYCHIATRIST

Director: Lori E. Raney, M.D.

Faculty: John S. Kern, M.D.; Marc D. Avery, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Define the needs and challenges related to behavioral health care in primary care; 2) Describe the typical roles for a primary care consulting psychiatrist in an integrated care team; 3) Describe rationale for providing primary care services in the mental health setting; 4) List models of care used to provide primary care services in mental health settings.

SUMMARY:
This course is designed to introduce the developing role of a psychiatrist functioning as part of an integrated care team. The first part of the course describes the delivery of mental health care in primary care settings and will delve into the specific job functions of the consulting psychiatrist. The second part is devoted to reviewing approaches to provide primary care in mental health settings and describes some emerging roles for psychiatrists in treating patients with serious mental illnesses and comorbid medical problems. The material includes a discussion of both the evidence base for this work and the practical "nuts and bolts" of primary care psychiatry delivery.

SEMINAR 06

FRONTIERS AND CLINICAL WORK WITH PEOPLE WHO ARE HOMELESS

Director: Hunter L. McQuistion, M.D.

Faculty: Monica Medina-McCurdy; Anthony Carino; Dilon Euler

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, participants should be able to: 1) Demonstrate knowledge of the current epidemiology and approaches to services among people with homelessness and behavioral health disorders; 2) Demonstrate knowledge of setting-specific rewards and special challenges of working with people who are homeless; 3) Demonstrate knowledge of how changes in healthcare delivery are affecting the nature of clinical practice focusing on homeless populations.

SUMMARY:
Latter-day homelessness has been a part of the American scene for over three decades. During that time, services have evolved in sophistication and behavioral health clinicians have gathered increasing skill and understanding in working with people who are homeless, often blazing a trail for mainstream clinicians. Examples are how advocacy, clinical flexibility, and the use of peer workers have informed the growing culture of recovery-oriented services; how outreach has modeled work with difficult to reach populations; and how working in highly collaborative team models has presaged integrated care.

Still, as the face of homelessness shifts and as the healthcare delivery system evolves, clinical services for homeless populations, in turn, continue to develop. After a brief overview of contemporary homelessness, particularly as it concerns clinical service, this course will focus on how trends in behavioral healthcare delivery are affecting clinical approaches with people who experience homelessness and behavioral health disorders, and how clinicians negotiate those systems to best advocate for the people they serve. Course presenters, both professionals and peers, will describe, and with the audience, discuss creative service initiatives, including the challenges at these frontiers. These services involve a specialized integrated behavioral health and primary care model and a unique health home initiative, with an in-depth discussion of clinical and ethical issues arising from the array of settings within which behavioral health clinicians encounter work with people who experience homelessness.

COURSE 03

DSM-5: WHAT CLINICIANS NEED TO KNOW AND PRACTICAL APPLICATIONS

Directors: Darrel Regier, M.D.; David J. Kupfer, M.D.

Faculty: William Narrow, M.D., MPH

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) List some of the primary significant changes in the classification of and diagnostic criteria for mental disorders from DSM-IV to DSM-5; 2) discuss some core clinical implications or modifications needed regarding the implementation of DSM-5; and 3) provide examples of how dimensional assessments are integrated into DSM-5 as well as their potential benefits and use.

SUMMARY:
Release of DSM-5 marks the first major revision to the classification and diagnostic criteria for mental disorders since DSM-IV was released in 1994. The focus of this course is to educate clinicians on the major changes from DSM-IV to DSM-5, including diagnosis-specific changes (e.g., criteria revisions) as well as broader, manual-wide changes (e.g., revised chapter ordering, use of dimensional assessments, integration of neuroscience and developmental material across the manual). The primary emphasis is on ensuring clinicians understand how these changes might impact patient care (e.g., insurance implications) and knowing what modifications might be necessary to implement these revisions in their practice (e.g., correct usage of ICD codes). The session will be led by the DSM-5 Task Force Chair and Vice-Chair, David J. Kupfer, M.D., and Darrel A. Regier, M.D., M.P.H., respectively, who will discuss revisions to the chapter structure and insurance implications of DSM-5. Their presentations will be supplemented by discussion of disorder-specific revisions from members of six of the 13 DSM-5 Work Groups, including Neurodevelopmental Disorders; Mood Disorders; Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders ; Feeding and Eating Disorders; and Personality and Personality Disorders. William Narrow, M.D., M.P.H., Research Director for the DSM-5 Task Force, will present on other clinical considerations in psychiatric diagnosis, such as use of new v and z codes to document other conditions that might warrant clinical attention and implementation of DSM-5's optional Section III measures (e.g., cross-cutting assessments; severity measures; the World Health Organization Disability Assessment Schedule 2.0).

COURSE 04

PRIMARY CARE SKILLS FOR PSYCHIATRISTS

Directors: Lori E. Raney, M.D.; Erik R. Vanderlip, M.D.

Faculty: Todd Wahrenberger; Lydia Chwastiak, M.D., M.P.H.; Charles E. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss useful lifestyle modifications; 2) Understand the current state of the art in treating diabetes, hypertension, dyslipidemias, smoking cessation and obesity; 3) Develop skills in understanding the use of treatment algorithms for chronic illnesses; 4) Explore the use of a primary care consultant to assist in treatment of patients if prescribing desired; 5) Discuss the rationale for psychiatrist prescribing with emphasis on liability and scope of practice concerns.

SUMMARY:
The excess mortality in persons with Serious and Persistent Mental Illnesses leading to a 25 year reduction in life expectancy is a well-known problem facing psychiatrists nationwide. Attempts to develop models that improve the overall health and health status have proven to be expensive and difficult and await the results of pilot projects that are underway. Many psychiatrists find themselves screening for cardiovascular risk factors (hypertension, diabetes, dyslipidemias, tobacco use and obesity) with continued inability to find adequate primary care resources for referral. In addition, some psychiatrists who have in-house primary care resources are finding themselves in positions where they are supervising primary care providers treating these problems. This leads them to a need to update their knowledge in treating the most common chronic illnesses leading to excess mortality to competently monitor progress that often includes state and local reporting on specific measures.

This Course aims to provide updated information to psychiatrists on the diagnosis and treatment of Diabetes, Hypertension, Dyslipidemias, Smoking Cessation and Obesity, using both didactic and case presentations. Algorithms for evidence-based treatment will be included. Ideally, physicians dual-boarded in both psychiatry and medicine will teach these modules to enhance the sense of the instructors understanding the predicament many psychiatrists are currently facing. Discussion time will include examining options for provision of care including psychiatrists providing some limited treatment of these disorders in their clinics with appropriate backup and support.

SEMINAR 07

FINDING YOUR IDEAL JOB IN PSYCHIATRY

Directors: Robert S. Marin, M.D., Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the impact of the changing health care environment on career options in psychiatry; 2) Recognize the opportunities and the rewards of public service career activities in psychiatry; 3) Articulate clearly his or her life life vision and priorities in creating an ideal job profile; 4) Demonstrate proficiency in developing his or her ideal job description and strategies for making it real.; 5) Discuss the elements of successful negotiation with potential employers.

SUMMARY:
This course will enable graduating psychiatric residents and early career psychiatrists to effectively envision a career they would find personally satisfying and fulfilling as a first step in finding their first job or changing positions. It will describe the health care environment with both the opportunities and challenges it presents. It will use interactive discussion and practical exercises to enable participants to articulate a life vision and an ideal career profile. Having accomplished this, participants will be engaged in a consideration of how job searches have typically been conducted by unprepared applicants and will identify many of the pitfalls that can be avoided by well-informed applicants who prepare adequately. The evaluation of potential employers and effective strategies for doing so will be considered along with strategies for negotiating a job description that is consistent with career goals and desired lifestyle. The course will provide ample opportunities for participants to discuss their particular questions and concerns, and will provide exposure to senior psychiatrists who have created careers that have been highly satisfying and in balance with a rich personal life. it will emphasize the necessity of taking care of one'e self in order to provide optimal care to persons to be served.

SEMINAR 08

ADDRESSING THE NEUROCOGNITIVE AND SOCIAL PSYCHOLOGICAL MECHANISMS UNDERLYING RACIST AND SEXIST EVENTS IN OUR DAILY PRACTICE

Director: Donald H. Williams, M.D.

Faculty: June Lee, DO; Princewell Onwere, DO

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, participants should be able to: 1) Demonstrate knowledge of the underlying neurocognitive and socio-psychological mechanisms of covert racism; 2) Demonstrate knowledge of how to identify, describe and categorize covert racist events in their own work place and become familiar with implicit association testing; 3) Demonstrate knowledge of strategies for addressing covert racist events in their own work place.

SUMMARY:
This session is designed to equip participants with the cognitive tools and intervention strategies to identify and modify the frequent covert racism that minority staff and minority patients encounter in majority health care and academic organizations. A major portion of the session will be applying the above tools and strategies to actual racist experiences of presenters and audience members. This session is designed to equip participants with the cognitive tools and intervention strategies to identify and modify

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INNOVATIVE PROGRAM

THURSDAY, OCTOBER 10, 2013

INNOVATIVE PROGRAM 1

EMERGENCY SERVICES

IP1-1
BERT-BEHAVIORAL EMERGENCY RESPONSE TEAM: AN EMERGENCY RESPONSE TO A PATIENT IN THE VERBAL STAGES OF ESCALATION IN A NON-BEHAVIORAL HEALTH ENVIRONMENT

Chairs: Patti Kelley, M.S.N., R.N., Sarah Lohse, B.S.N., R.N., Gayle L. Reneer, B.S.N., M.B.A., R.N., Lawrence F Kuhn, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Demonstrate a thorough understanding of the benefits of a specially trained behavioral emergency response team in a hospital; 2) Recognize the challenges experienced by medically trained (non-psychiatric) personnel in a hospital caring for patients who experience an escalation event; 3) Identify the benefits of an individualized therapeutic approach to patients and visitors regarding the tailoring of interventions based on the level of escalation; 4) Recognize the improved employee safety outcomes resulting from the individualized treatment and therapeutic intervention in response to the level of escalation of the patient.

SUMMARY:
Background: As medical and psychiatric resources continue to deplete across the country, patients with a mental health diagnosis are at risk for receiving inconsistent outpatient medical care. As a result, these patients frequently visit emergency departments and require admissions to not only behavioral health departments but also medical, surgical and ICU departments as well. At SSM Healthcare in St. Louis, we identified that the medically trained physicians, nurses and support staff did not feel adequately trained to respond to behaviors of escalating patients. In addition, the only available resource was designed to respond to a patient who had surpassed the verbal symptoms of escalation and was presenting physical behaviors of escalation.

Methods: In response to the concerns of the medical personnel, the Behavioral Health Department partnered with Security and Nursing Operations to create a layer of support that provides a prompt response to a patient experiencing the verbal stages of a behavioral crisis. This was the beginning of BERT: Behavioral Emergency Response Team which differs from the traditional method of response to an escalation event (i.e. Code Strong) in that a staff member activates it when the patient is still demonstrating verbal behaviors opposed to physical behaviors. In addition, the team is not paged overhead and a smaller, specially trained team responds to build rapport with the patient and utilize verbal de-escalation skills opposed to physical interventions. The implementation of the program required support from the departments involved and education of not only responding personnel but also front line staff activating the team in the event of a crisis.

Results: With the initiation of BERT, we have experienced both qualitative and quantitative successes. Of particular note, through our collaborative relationships between all departments involved including the emergency department, medical departments, behavioral health, security and nursing operations, we have created a therapeutic environment for our patients based on a foundation of respect and provide education and support to employees who would otherwise feel unsupported. Also, we have seen a trend reduction in the utilization of the traditional response to an escalation event (Code Strong) which utilized employees not trained in de-escalation techniques, placing them at risk for injury. In addition, of the 57 BERTs we have performed at the pilot hospital, we have only had to use a physical intervention on 2 occasions, resulting in a 96% success rate of verbal de-escalation. Finally, we have witnessed a reduction in physical restraints in the emergency department since the BERT initiative has been implemented.

Conclusion: The successes of this initiative have the potential to significantly impact how we can best serve escalating patients in non-behavioral health environments across the country.

IP1-2
RESOLVING A CITY-WIDE CRISIS OF POLICE DIVERSION & PSYCHIATRIC PATIENT BOARDING IN THE EMERGENCY DEPARTMENT

Chair: Jon S Berlin, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1)Identify the clinical approaches to psychiatric emergencies that increase engagement and reduce the need for locked inpatient services; 2) Recognize the risks of inpatient commitment and calibrate one's risk tolerance to the community standard; 3) Appreciate the impact of taking a broad-based leadership role in addressing a community-wide crisis of psychiatric patient boarding and police diversion; 4) Appreciate the value of designating the boarding and diversion rate as a quality indicator to be shared by the entire mental health community; 5) Describe a multi-pronged approach of medical leadership, mission focus, clinical & program innovation, public-private-academic collaboration, community education, and legislative action.

SUMMARY:
Psychiatric bed and hospital closures in public, private and academic sectors have precipitated a crisis in many cities of psychiatric boarding in emergency departments (ED's), medical wards and psychiatric emergency services (PES's). Patient care, staff morale and the public image of psychiatry suffer terribly. The creation of specialized PES'S can be a tremendous boon and safety valve for a burdened community. But they are costly and may become an easy place for community providers to dump difficult cases. Ultimately, a safety net service such as a PES reaches maximum capacity and psychiatric patients are forced to board in ED's and PES's waiting for an inpatient bed.

An innovative multi-pronged program in Milwaukee is described that combines strong medical leadership, mission clarification, clinical innovation, program development, improved documentation, public-private-academic collaboration, community education and legislative action. Key features include intense focus on early engagement and crisis reduction with patients using motivational interviewing, solution focused care, psychological first aid, non-coercive de-escalation, systems approaches and interviewing for acuity and the acute precipitant. The 'treatment model' in emergency psychiatry is favored over the 'triage model'. Emphasis is placed on helping practitioners find the optimal set point of risk tolerance to facilitate appropriate diversion from inpatient settings. CIT training for police and regular education of emergency medicine personnel are also useful. A crisis that started as a community outcry in 2004 and peaked with threats of legal action in 2007 was well on its way to being resolved by 2008 and has continued in remission to the present day.

A crucial step is building a task force of community stakeholders that buy into the idea that the rates of boarding and police diversion are primary quality indicators shared by everyone involved. Creative thinking replaces finger pointing and fault-finding. Private hospitals and psychiatrists are helped to expand their clinical repertoire and psychiatry residents are trained to the needed range of concepts and skills. Local solutions, such as public-private partnerships and jointly-funded, community-based crisis beds, are found.

Also discussed are new and continuing threats, strategies for maintaining the progress made, and ideas for even greater quality improvement.

INNOVATIVE PROGRAM 2

SUICIDE AND DEPRESSION

IP2-1
IMPROVING TREATMENT OF PATIENTS WITH DEPRESSION IN A PRIMARY CARE MEDICAL HOME MODEL

Chair: Benjamin Daegun Schanker, B.A., B.S.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize innovative systems of treating depression in primary care populations; 2) Identify challenges with the increasing burden of depression as an illness and the shortage of mental health providers; 3) As a psychiatrist or mental health provider, facilitate the manner in which primary care physicians treat their patients with depression; 4) Identify trajectories of innovation as the American health care system evolves to integrate accountable care organizations

SUMMARY:
Depression is highly prevalent (~10%) in the general population and more than half of all depression cases are managed by primary care providers rather than psychiatrists. Treatment of depression in primary care demands frequent visits, time and resources that are scarce in a busy practice environments. Collaborative care models for depression such as IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) have been demonstrated to improve treatment of depression in primary care by improving outcomes and decreasing costs. A collaborative depression care team was piloted at the Beth Israel Deaconess Medical Center as part of the Harvard Medical School Primary Care Innovation Program. The team was comprised of representatives from Psychiatry, General Medicine and Social Work, as well as a patient Care

Manager who served as a bridge between patients, primary care providers, and a consulting psychiatrist. For uncomplicated cases of depression, Care Managers function in many ways as therapists, while primary care physicians function as prescribers, and psychiatrists as consultants. Care managers provide medication adherence reminders or inquiries, antidepressant side effect counseling, PHQ-9 Depression Inventory administration, behavioral activation, and problem solving therapy. In a collaborative team, the talent and knowledge of psychiatrists is leveraged for the most complex cases of depression, while the shortage of psychiatrists for patients with depression is addressed by primary care physicians. Psychiatrists are additionally ale to serve as educators of primary care physicians to improve the delivery of care for patients with depression. Finally, care can be delivered at a lower cost with improved patient outcomes.

IP2-2
SUICIDE IN U.S. VETERANS

Chair: Jamshid A. Marvasti, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Learn about the prevalence and epidemiology of suicide in veterans; 2) Learn about contributing factors to suicide in veterans; 3) Learn about interaction between PTSD, TBI, and suicide in veterans of war.

SUMMARY:
More than two and a half million U.S. military personnel were involved in war in the Middle East during the last decade, and most have returned to the United States. Grossly, one third returned with PTSD, and almost one half are suffering from psychiatric and substance use disorders. The number of suicides among combat veterans has substantially increased to the point where the military and community are concerned. The act of suicide may contain a message, a protest, an act of revenge, or an escape from unbearable suffering. This paper will focus on one of the many unfortunate consequences of war: self-destructive behavior in veterans.

Amidst the highly publicized spike in veterans' suicides, the effect of combat trauma is being investigated more than ever before in our country's history. This paper explores the connections between suicide and combat trauma, PTSD, TBI, side effects of medication, and substance abuse. Also included is an exploration of the impact of participation or exposure to atrocities and the killing of enemy combatants, plus adverse impact on self-image and core beliefs of soldiers. Distinctions are made between several stages and/or categories of suicide, including suicidal ideation, attempt, parasuicidal behavior, and "inviting suicide."

Research reveals several risk factors for suicide in veterans, which include multiple deployments and the severity of war trauma and PTSD in soldiers. The combination of PTSD and TBI should always raise a red flag for the risk of aggression toward self (suicide) or others (homicide). TBI, especially damage to the frontal lobes of the brain, is considered to increase suicidal risk. Akathisia (restless leg syndrome), which can be a side effect of antipsychotic and SSRI antidepressants, may be associated with suicide. Additionally SSRIs are known to cause suicidal ideation in some young people.

There will also be an overview of the ethical conflicts for combat clinicians who must choose between supporting the warrior or not supporting the war. For example, should they evacuate a traumatized (suicidal) soldier or make an attempt at rehabilitation on site? One decision may save the soldier but decrease the fighting capacity of the unit. This paper emphasizes that a clinician must remain a clinician at all times, even in a combat zone, and cannot ignore this responsibility in order to conserve the fighting force. That consideration is the duty of the military command and politicians who initiated the war.

FRIDAY, OCTOBER 11, 2013

INNOVATIVE PROGRAM 3

CHILD MENTAL HEALTH

IP3-1
PRESERVING AND PROMOTING MOTHER AND BABY MENTAL WELLNESS: A CROSS-SYSTEMS APPROACH

Chairs: Joseph P. Merlino, M.D., M.P.A., Eva A Sanders, L.C.S.W.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Expand the common wisdom of management for the pregnant woman on an inpatient psychiatric unit beyond simple psychopharmacology to a recovery-oriented, resiliency-based system of care; 2) Understand and integrate the impacts of parental mental illness on resiliency and strategies to support self-efficacy and maximize mother/baby success; 3) Conceptualize and coordinate a safe, sustained, comprehensive aftercare and transition plan from inpatient setting to the community.

SUMMARY:
We have established an integrated inpatient and outpatient peri-neonatal care program in at Kings County Hospital Center in Brooklyn, NY, the goal of which is to improve the overall care and outcomes for both the expectant mother and child before and up to a year after birth.

Prior to birth specific steps presented will include coordinating care with OB team, psychopharmacology considerations, outpatient and inpatient care coordination, maternal and family coaching ranging from basic infant care, breastfeeding etc; to more sophisticated planning, such as to ability to identify worsening of psychiatric symptoms and ability to address them promptly, minimizing impact on both mother and child. Data gathering of relevant data points may include neonatal birth weights, hospitalizations of both infant and mother etc.

Further focus of integration of psychological, medical and treatment refractory population in terms of long term planning and placement. In addition to a general paucity of specialized outpatient resources, treatment resistance in pregnant patients is a true clinical challenge with the priority of making ECT and other brain stimulation techniques available via improved care coordination.

Finally, data and research driven approaches to care, cross-systems care coordination, including custody post-delivery, post-discharge whole-person recovery support; relevant trauma considerations and need for specific coaching in case of cognitive and severe psychiatric impairment.

IP3-2
PREVENTING EARLY CHILDHOOD ADVERSITY BY THE CERTIFICATION OF PARENTHOOD

Chair: Jack C. Westman, M.D., M.S.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Apply the public health principles of primary, secondary, and tertiary prevention to psychiatric disorders; 2) Stimulate thinking about the right of newborn babies to have parents who can give them an opportunity to succeed in life; 3) Define and describe Parenthood Planning Counseling; 4) Describe a process for implementing a Parenthood Pledge and the certification of parenthood.

SUMMARY:
As it now stands, child and adolescent psychiatry focuses on the diagnosis and treatment of psychiatric disorders. The field would better serve children, adolescents, their families, and society by employing the public health principles of primary, secondary, and tertiary prevention, as does pediatrics. The fact that one third of our children in the United States are not thriving creates a compelling need for the primary prevention of early childhood adversity.

Wisconsin Cares, Inc., has proposed a significant step to improve the chances newborns will have to succeed in life through Parenthood Planning Counseling instituted with a family whenever a person who has a legal and physical custodian or a legal guardian becomes pregnant and chooses to continue the pregnancy to childbirth.

In this proposal, the birth certificate would be modified to become a parenthood certificate as well. The mother and father, if known, would be informed of her or his custodial duties as part of the birth certificate application and would sign a Parenthood Pledge to care for the newborn child. Just as non-marital fathers are now informed about and legally acknowledge their financial support obligations, all parents of newborns would acknowledge their custodial duties to the child as commonly defined in family courts.

If a mother or father is in the legal and physical custody as minors or under the legal guardianship of another person(s) as adults, that person(s) would co-sign the Parenthood Pledge and be presumed legal and physical custodian(s) of the dependent person's child unless she or he is unable or unwilling to accept this responsibility. This would continue until the mother or father becomes self-sufficient. If all available presumptive custodians decline this responsibility or do not meet kinship-care standards or if the mother already is under the custody of the state and the father is not eligible to assume custody, legal and physical custody of the newborn child would be assumed by the state through a Child in Need of Protective Services action. Then an adoption plan would be made for the newborn child prior to birth by a Parenthood Planning Counseling Team with the addition of a guardian ad litem for the unborn child.

A Parenthood Pledge and Parenthood Planning Counseling would help ensure that newborns have families that are capable of rearing them rather than exposing them, too often knowingly, to early childhood adversity and waiting to intervene until after they are damaged by neglect and/or abuse.

INNOVATIVE PROGRAM 4

ADDICTIONS

IP4-1
ALCOHOL DETOXIFICATION: A RISK STRATIFICATION APPROACH

Chairs: Nick C Mellos M.D., Louis E. Trevisan, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Discuss the prevalence of alcohol use disorders at VA Connecticut; 2) Review treatment options for the management of Alcohol Detoxification; 3) Discuss the development of an Alcohol Detoxification Risk Stratification Algorithm and it's clinical rational as a means to enhance patient care and outcomes; 4) Discuss process implementation of the Algorithm hospital wide; 5) Review challenges associated with the implementation of the Algorithm.

SUMMARY:
Veterans with alcohol disorders make up a large portion of the population we treat at VA Connecticut (VACT) and frequently present in need of alcohol detoxification. We conducted a Quality Improvement study to assess current practice patterns associated with alcohol withdrawal based on anecdotal data suggesting a relative high prevalence of Delirium Tremens (DT's) on our medical floors and update our alcohol withdrawal guidelines. Our study was conducted in two steps. Step one investigated current practice patterns using a semi-structured questionnaire, assessed the prevalence of patients with alcohol related disorders, and assessed physical restraint episodes associated with patients with alcohol related disorders. Step two was organized around developing and implementing improved alcohol withdrawal treatment guidelines. Based on our questionnaire we discovered current Alcohol Withdrawal Guidelines were not consistently followed, multiple practice patterns were being used, and communication barriers were identified. We also discovered that common alcohol assessment tools were not being utilized, identified concerns regarding inadequate hand-off of information, issues regarding staff stigmatization of patients with alcohol related problems, and concerns regarding injury surrounding patients with DT's. In regards to prevalence we discovered the overall average percentage of patients with alcohol related problems during a one week 'snap shot' period within the Emergency Departments and all inpatient beds was 47%. Finally we reviewed restraint data for November and December of 2008 and discovered that 36% and 38% of restraint episodes were associated with patients with alcohol related disorders. Based on this data we developed a broader multidisciplinary team to re-examine our treatment guidelines and develop a universal treatment approach with the aim to improve care and outcomes. We conducted a review of the literature, reviewed multiple alcohol treatment protocols throughout the country, and utilized our clinical experience to develop what we feel is a novel alcohol withdrawal risk stratification tool and treatment algorithm. We tested this tool on over 125 veterans to help refine and verify its clinical usefulness. In parallel we developed a nursing led screening process utilizing Audit-C, CAGE, Alcohol breath testing, and CIWA to be conducted when patients present for acute hospital treatment. We also developed electronic order sets to help standardize care delivery and expedite order entry. Finally we have implemented this process hospital wide. We believe we have developed new alcohol detoxification guidelines that have overcome many of our challenges and attain a substantial portion of our goals. In the future we hope to obtain additional resources to more qualitatively measure and assess treatment outcomes associated with the implementation of this algorithm.

IP4-2
INTEGRATING SUBSTANCE ABUSE TREATMENT IN THE CONTINUUM OF CARE FOR MENTALLY ILL HOMELESS PERSONS: A DECADE OF LESSONS LEARNED

Chair: Richard C. Christensen, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Have a better understanding of the complex barriers faced by mentally ill, homeless persons in accessing substance abuse treatment; 2) Identify different models of substance abuse treatment that have the potential of being adapted to meet the complex needs of homeless persons with comorbid conditions; 3) Be able to appreciate the need for a model of treatment that integrates addiction services into a continuum of care that also includes case management, primary care, behavioral health and housing services that foster recovery and inclusion

SUMMARY:
It has been estimated that homeless adults are nearly 2-5 times more likely to suffer from substance use disorders when compared to persons in the general population. In addition, comorbid conditions associated with mental illness and general medical conditions present additional challenges for homeless persons motivated to access substance abuse treatment. This Innovative Program will describe the evolution of a continuum of services resulting from an academic-public sector liaison in Jacksonville, Florida, based at a large urban center for homeless persons. The different components of this model of integrated care (e.g., psychiatric street outreach, shelter-based medical/social case management services, co-located primary care, psychiatric services and addiction treatment within a federally qualified health clinic, and assistance in obtaining transitional/permanent housing) are all service adaptations that have been implemented over a ten year period to better meet the needs of this highly vulnerable population. This presentation will specifically highlight the evolution, development and implementation of an integrated, co-located addiction service within this continuum of care. Beginning ten years ago with a "sequential" model of addiction treatment and mental health care, and undergoing several service delivery adaptations over the past decade , the current model of care is based upon the principles of integration, on-site co-location and transdisciplinary collaboration. From a "best practices" perspective, we view this evolved model as essential to promoting engagement, reconnection and recovery for homeless persons suffering the effects of mental illness and substance use disorders in the Jacksonville community. Moreover, this integrated model has the potential of being replicated in other communities pursuing strategies to shape substance use services to better meet the needs of this complex population.

FRIDAY, OCTOBER 11, 2013

INNOVATIVE PROGRAM 5

EVIDENCE BASED PRACTICE IN COMMUNITY SYSTEMS

IP5-1
"CONSIDERING CLOZAPINE": A CONSUMER-ORIENTED INITIATIVE ADDRESSING EVIDENCE-BASED MEDICATION CHOICE IN A PUBLIC MENTAL HEALTH SYSTEM

Chairs: Cassis Henry, M.A., M.D., Lloyd I Sederer, M.D., Jay Carruthers, M.D., Thomas S Stroup, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the rationale for the New York State Office of Mental Health's initiative to promote evidence-based use of clozapine and other antipsychotic medication; 2) Recognize strategies for engaging consumers in assessing clozapine as a choice for them, including the development and dissemination of a web-based consumer educational program; 3) Describe additional and complementary tools

that can be used by a public mental health system to safely increase the appropriate use of clozapine.

SUMMARY:
Clozapine remains the most effective proven treatment for schizophrenia refractory to other treatments. Nonetheless, in New York state (as nationally), it is underused. In recognition of this fact, the New York State Office of Mental Health launched its Best Practices Initiative on Clozapine. A central element is "Considering Clozapine," an innovative, web-based consumer education module on clozapine and other antipsychotic medications designed to inform shared decision-making about medication through an introduction to the role of clozapine. This freely accessible and interactive module has been created, promoted and disseminated in New York state as part of a broader initiative to increase access to clozapine by addressing previously identified barriers to its use. This module features peer testimonials and interactive strategies to engage consumer-users in substantive consideration of available pharmacotherapies by exploring the potential personal impact, positive and negative, of clozapine and other medications. This presentation will review the design of the module, consumer and provider feedback, and the place of this consumer educational effort in the larger effort to support more rational use of psychotropic medication within the New York state public mental health system.

IP5-2
EVIDENCE-BASED PRACTICE AND INNOVATION CENTER (EPIC): ACHIEVING OUTCOMES THROUGH PROMOTION OF EMPIRICALLY SUPPORTED TREATMENT AND PHILOSOPHY

Chairs: Matthew O. Hurford, M.D., Authur Evans, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the growing importance of empirically-supported treatments in the behavioral healthcare landscape; 2) Understand the opportunities for psychiatrists to partner with government, funders, and academia to promote the effective implementation of innovative care based on best evidence; 3) Appreciate the philosophical shift toward outcomes and the role of evidence-based practices in achieving them that will serve as the foundation for the healthcare funding environment of tomorrow.

SUMMARY:
Evidence-based practices (EBPs) will play an increasingly prominent role in the behavioral health care delivery system under healthcare reform. In 2012, The Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) created the Evidence-Based Practice and Innovations Center (EPIC) to promote the dissemination and implementation of an evidence-based philosophy and practice throughout Philadelphia's behavioral health system. The Center functions as an educator, consultant and support entity for the utilization of evidence-based practices and approaches that are aimed towards successful and sustained outcomes for all individuals in recovery. This presentation will describe the unique collaboration between government/funder, provider, and academic partner that led to the formation of EPIC. The presentation will also provide lessons learned from the Philadelphia system's experience implementing large-scale EBP training initiatives in cognitive therapy (CT), dialectical behavioral therapy (DBT), and trauma-related therapies including prolonged exposure (PE), trauma-focused CBT (TF-CBT) and the Sanctuary Model.

INNOVATIVE PROGRAM 6

VETERANS IN CRISIS: SPECIAL INITIATIVES

IP6-1
LEGAL ASPECTS OF COMBAT TRAUMA AND PTSD IN VETERANS: AGGRESSION, CRIMINAL CONDUCT, AND THE NEED FOR SPECIAL VETERANS' COURTS

Chair: Jamshid A. Marvasti, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Become familiar with the psychological, spiritual, and moral impact of war in warriors; 2) Learn about the connection (if any) between PTSD/war trauma and criminal activity in returning veterans; 3) Become familiar with the advantages and disadvantages of having special courts for combat veterans who engage in criminal activities.

SUMMARY:
The consequences of war extend far beyond the battlefield. Although war and aggression may be evolutionary, they do not come without a cost. Among the most widely unreported casualties of war are those that involve criminal activity on the home front. It is not uncommon for veterans to have difficulty readjusting to civilian life. A number of returning combat veterans have been charged with criminal activity, and in many of these cases the charges involve felonies. Often these crimes take place years after the veteran's return. In January of 2008, The New York Times published a list of 121 veterans who were arrested and charged in homicide cases following their return from deployment in Iraq or Afghanistan.

This paper discusses the connection between PTSD in combat veterans and their criminal activities after they have returned from war. Although some argue that the relationship between PTSD and criminal behavior may be a sort of "chicken or the egg" scenario, where it is difficult to determine which came first, several models have been proposed to address this problem. It will present forensic cases of veterans who committed various felonies, including homicide. Defense attorneys have used war trauma, PTSD, and military training and indoctrination as mitigating factors during the penalty phases of trials. Attorneys have often blamed the military for their clients' actions, arguing that the Army and Marines train their personnel to become killers. Many feel that it is the military's responsibility to deprogram these individuals before returning them to the community.

This discussion of veterans in the criminal system includes the controversial subject of jail diversion programs and the advantages and disadvantages of having a special treatment court for veterans. Special courts may offer clear evidence that veterans with PTSD who commit crimes may be able to get help through this type of court. For these courts to work, the VA must have enough clinical resources for the purpose of rehabilitating soldiers.

IP6-2
VALIDATING THE COVR™ CLASSIFICATION OF VIOLENCE RISK SOFTWARE FOR MILITARY INPATIENT TREATMENT

Chair: Paul J. Howie, Psy.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the latest diagnostic measures to accurately estimate the risk of an acute military psychiatric patient becoming violent towards family members, fellow soldiers and themselves; 2) Understand the personal, historical, contextual, and clinical factors that collectively classify a military patient's risk for potential violent acts following treatment; 3) Current tools such as the Historical-Clinical-Risk Management 20 (HCL-20) structure only review specified number of choices and measurement of risk factors within a general risk summary; 4) the Violence Risk Appraisal Guide (VRAG) completely structures the violence risk assessment process with no allowance for clinical review or interviews;5) COVR Classification of Violence Risk , an evidence based, interactive software program shows promise in the utility in which the risk factors and clinical interviews are combined to yield an estimate

SUMMARY:
As thousands of military veterans return from wars in Afghanistan and Iraq, broad public attention is paid to reports of violent acts committed stateside by those suffering from mental health disorders. As mass media continues to report these acts, society is left with unanswered questions, such as: Why are military veterans returning stateside with untreated mental health problems? How are military veterans screened for posttraumatic stress disorder (PTSD), and often resultant violent acts, prior to their return? Oftentimes, veterans that commit aggressive crimes, such as homicide, domestic violence, and alcohol related crimes, or other violent acts, have received treatment in military based acute in-patient psychiatric settings. Mental health professionals providing treatment within these settings are pressured to provide explanation for these acts and to likewise refer these veterans to after care appropriately. Unfortunately, these providers often lack diagnostic measures to accurately estimate the risk of an acute psychiatric patient becoming violent towards.

The Classification of Violence Risk (COVR™), an available evidence based, interactive software program, allows for professionals to create a statistically valid estimate of a patient's violence risk post discharge from acute in-patient psychiatric care (Monahan et al., 2005). Personal, historical, contextual, and clinical factors collectively classify a patient's risk for potential violent acts following treatment. Military hospital settings have yet to pilot use of the COVR™ program and likewise lack use of other classification tools. Doing so could optimize ability of military hospitals to identifying which military members are in most need of interventions including mental health and other medical services following acute in-patient psychiatric treatment. Equally, the COVR™ program could lead to improved follow up treatment of service members to allow for improved adjustment to life post-deployment. Violent acts and tragic crimes perpetuated by returning veterans would ultimately decrease.

Current tools such as the Historical-Clinical-Risk Management 20 (HCL-20) structure only review specified number of choices and measurement of risk factors within a general risk summary and the Violence Risk Appraisal Guide (VRAG) completely structure the violence risk assessment process with no allowance for clinical review or interviews. In additional, other lengthy instruments such as Hare Psychopathy Checklist-Revised must be obtained by a trained interviewer in conjunction with VRAG for accurate risk assessment. These structured risk assessments use hand written tabulation which can introduce errors and is solely based on "main effects" approach to structured risk assessment in which all subjects are asked tre asked the same question with each answer weighted and summed to produce a score for an overall estimate of risk.

LECTURES

THURSDAY, OCTOBER 10, 2013

LECTURE 01

EARLY DETECTION AND INTERVENTION OF PSYCHOSIS PRONE YOUTH

Lecturer: Raquel Gur

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize early signs and presentation of Psychosis Spectrum; 2) Identify brain – behavior measures that relate to early presentation of Psychosis Spectrum; 3) Consider therapeutic interventions.

SUMMARY:
A growing body of scientific evidence suggests that severe mental illnesses are disorders of brain development that are already emerging by adolescence. The onset of psychosis is commonly preceded by diverse and nonspecific changes in behavior and functional capacity, that can be difficult to distinguish from the common tribulations of adolescence and that occur over time periods that differ across individuals.

We have applied complementary lines of research in order to examine cognitive and emotion processing in young people who also participated in a brain imaging study. A large population based study compared youths who endorsed psychotic symptoms to typically developing participants. The psychosis prone group showed impaired performance in executive and emotion processing measures, similar to those seen in individual with schizophrenia. Furthermore, structural MRI showed decrease in brain volume and fMRI indicated abnormal activation in fronto-temporal brain systems related to performance on neurobehavioral probes of working memory and emotion identification.

The pattern of brain dysfunction evident in psychosis prone youths is similar to that observed in people with schizophrenia and suggests that aberrations in brain development are evident before clinical presentation.

In this session a review of the status of the filed of early identification of individuals at the prodromal state will be followed by presentation of the Philadelphia Neurodevelopmental Cohort. The session will conclude by discussion of treatment challenges and opportunities to impact the developmental trajectory of young people with psychosis spectrum features.

LECTURE 02

THE ROLE OF LEADERSHIP AND INTERNATIONAL KNOWLEDGE EXCAHNGE IN TRANSFORMING MENTAL HEALTH SERVICES

Lecturer: Fran Silvestri, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the way in which leadership can enable the replication and adaptation of emerging effective practices in service delivery; 2) Demonstrate knowledge of the use of international collaboration to remain abreast of innovation, adapt and implement new effective approaches to service delivery within the United States. ; 3) Demonstrate knowledge of the approach adopted by one international initiative to foster knowledge exchange and support service improvement in light of emerging evidence.

SUMMARY:
The institute of medicine has calculated that in the U.S. it takes more than 18 years once a health service is proven to be effective for the approach to be adapted and replicated more widely across the country. The time frame is even longer for innovations from overseas to be adapted and implemented within the U.S.

The field of mental health is rapidly changing and more effective practices are being identified both within the U.S. and in other countries. The challenge is to shorten the length of time between the emergence of new and promising practices from around the world and their wider implementation.

Capable service leadership is key to the wider adoption of effective practices that emerge as a result of innovations. In order to adapt mental health systems in light of new knowledge, leaders need to be well informed about effective and innovative services, open to learning and able to foster the will to change and improve.

This presentation will describe the way in which the international initiative for mental health leadership provides a mechanism to support leaders wishing to improve services. This initiative establishes global linkages between mental health leaders, provides opportunities for leaders to exchange knowledge about innovations and effective services, and fosters the establishment of partnerships between leaders to enable them to rapidly import, adapt and implement new approaches to service delivery.

LECTURE 03

BEHAVIORAL HEALTH: CHALLENGES AND OPPORTUNITIES IN CHANGING TIMES

Lecturer: Pamela Hyde, J.D.

LECTURE 05

HEALTH CARE/HEALTH INSURANCE REFORM AND PSYCHIATRIC SERVICES

Lecturer: Howard H. Goldman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of how the ACA will cover psychiatric services; 2) Demonstrate knowledge of what psychiatric services will not be covered by the ACA; 3) Demonstrate knowledge of how psychiatric services will be financed in the public sector under the ACA.

SUMMARY:
The Affordable Care Act (ACA) will have important implications for psychiatric services. There will be improvements in terms of populations covered by health insurance reforms and there will be new emphases on preventive services and integration of behavioral health care with general medical and surgical services. Behavioral health services are mandated by the reform, and services must be covered with parity benefits. Some services, however, primarily supportive services that do not fit traditionally in a health insurance benefit (e.g. supported employment) are unlikely to be covered by the ACA. Some may be covered by Medicaid State Plan Amendments, but like the Medicaid expansion, itself, this will be decided on a state-by-state basis. There continues to be a need for public financing of certain services and for a public mental health authority of some type even with health care reform following full ACA implementation.

OCT 11, 2013

LECTURE 06

WHAT DOES IT TAKE TO TRANSFORM A LARGE, COMPLEX BEHAVIORAL HEALTH CARE SYSTEM? IMPLICATIONS FOR HEALTHCARE REFORM AND BEYOND

Lecturer: Authur Evans, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand a framework for large scale system change for a behavioral health care system; 2) Identify the major trends in health care reform and the implications for behavioral health care.; 3) Identify the implications of health care reform for behavioral health practitioners, administrators, and policy makers.

SUMMARY:
Transformation of behavioral health services to a recovery and resilience-oriented system of care is a priority for the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). Such a system of care represents a shift from a professionally driven acute services delivery system to one that provides long-term supports in the community and recognizes multiple pathways to achieving social and emotional wellness for individuals, families, and communities. This presentation will provide an overview of large-scale recovery transformation in Philadelphia and highlight how a recovery framework provides the most viable approach for the behavioral health field to respond to significant changes in health care. In addition, the presentation will discuss opportunities and challenges in system transformation and health care reform and key implications for health practitioners, administrators, and policy makers.

LECTURE 07

THE CHALLENGE AND PROMISE OF BUILDING EARLY INTERVENTION PROGRAMS FOR SCHIZOPHRENIA

Lecturer: Lisa B Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the role of pathways to care and duration of untreated psychosis (DUP) and strategies for reducing DUP in maximizing the benefits of early intervention; 2) Understand the role of optimal early intervention services (EIS) in maximizing the benefits of early intervention; 3) Identify clinical and services system challenges in mounting programs to maximize the benefits of early intervention.

SUMMARY:
This session will evaluate the promise and opportunities of early intervention for schizophrenia. Elucidating pathways to care, and minimizing duration of untreated psychosis as well as innovative early intervention services play important roles in the potential for maximizing outcomes. The experience and challenges of the Raise Connection program, conducted in New York and Maryland, and its real-world expansion, ONTRACKNY, will be discussed. The clinical and service system challenges will be highlighted

LECTURE 08

INTERNATIONAL MEDICAL GRADUATES: ENRICHING AMERICAN PSYCHIATRY AND GOOD-WILL AMBASSADORS ENHANCING WORLD MENTAL HEALTH

Lecturer: Jagannathan Srinivasaraghavan, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the contribution of International Medical Graduates to enrich American Psychiatry; 2) Demonstrate knowledge of how cultural diversi-

ty of International Medical Graduates aids understanding of mental illnesses in a multi-cultural society; 3) Demonstrate knowledge of enhancing world mental health by psychiatric education and services by individuals and groups of International Medical Graduates.

SUMMARY:
International Medical Graduates (IMGs) constitute nearly 25% of all members of American Psychiatric Association (APA) numbering nearly 8000. There are approximately 4000-5000 IMG psychiatrists who are not members of APA. Among the medical specialties, psychiatry has one of the largest numbers of IMGs. IMGs hail from about 150 countries around the world and have made a mark in all fields of psychiatry including academic, administration, organizational, research, public and private sectors. IMGs are the back bone of most public sector services in the United States. The cultural diversity of IMGs has tremendously assisted in understanding of the presentation of mental illnesses in a multi-cultural society. Larger groups of IMGs have organized ethnic psychiatric societies such as the Asian Indian, Pakistani, Filipino, Korean, Chinese, Hispanic, Nigerian, Greek, Iranian and Arab. These groups have fostered to the new arrivals of IMGs to get familiar with American psychiatry and further connect with country of origin or region for improving psychiatric education and services. There are influential individuals who nevertheless venture to advance knowledge and services in their country of origin or region as well. This presentation will highlight how IMGs act as good-will ambassadors in enhancing psychiatric education, disaster- relief and research throughout the world. The presenter would add personal observations from his extensive travels around the world, how IMGs are in a unique position to influence and enrich American psychiatry but also enhance and improve the world mental health that provides personal satisfaction on the one hand and leaves the world a better place to live for the future generations on the other.

LECTURE 09

IMPROVING HEALTH AND HEALTHCARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESSES: A PUBLIC HEALTH PERSPECTIVE

Lecturer: Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the importance of a public health perspective in improving physical health and health care for people with serious mental illnesses; 2) Identify opportunities under health reform to develop population-based approaches to improving care for people with serious mental illnesses.

SUMMARY:
In recent years issue of poor physical health for people with serious mental illnesses has moved from a research and policy "orphan" to a central concern in the mental health advocacy community. Addressing this problem in patients with serious mental illnesses will require a public health approach addressing poor quality of care, adverse health behaviors and social determinants of health in people with serious mental illnesses. The Affordable Care Act offers opportunities to implement novel organizational approaches to care delivery, but only if these are supported by high quality care delivery on the ground. The lecture will discuss current clinical, research, and policy initiatives in the area, and new opportunities for public sector psychiatrists.

LECTURE 10

PREVENTING THE FIRST EPISODE OF PSYCHOSIS

Lecturer: William R. McFarlane, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify early signs of psychosis; 2) Demonstrate knowledge of the present evidence for preferred treatments of early stages of psychosis; 3) Demonstrate knowledge of the basic features of preferred treatments of early stages of psychosis.

SUMMARY:
Prevention of onset of psychosis has recently been found to be effective across 10 international studies. This lecture will describe the background, research methods, treatments and interventions and results for a national effectiveness trial of early identification and intervention to prevent the initial onset of psychosis. This is the largest clinical trial yet undertaken, involving six cities or multi-county catchment areas in the United States. Among youth at risk for psychosis there was a significantly superior effect for Family-aided Assertive Community Treatment compared to standard- or no-treatment controls. 6% of youth at risk had a psychotic episode, compared to an expected rate of 29-35%, while baseline functional levels were fully maintained through 2 years of treatment.

Given the success of more recent county-wide implementations and promising long-term outcomes, prevention of psychosis has now been demonstrated to be feasible and effective. Implications for practice will be emphasized and illustrated with clinical examples.

LECTURE 11

THE AMA AND 21ST CENTURY MEDICINE

Lecturer: Jeremy Lazarus, M.D.

LECTURE 12

DEVELOPMENT AND TESTING OF COMMUNITY-BASED MENTAL HEALTH SERVICES IN LOW- AND MIDDLE-INCOME COUNTRIES: AN EXAMPLE FROM LATIN AMERICA

Lecturers: Ezra Susser, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of adapting evidence-based mental health services to low and middle income countries (LMICs); ; 2) Demonstrate knowledge of using regional trials and regional networks can accelerate improvement of mental health services in s; 3) Demonstrate knowledge of a specific example in Latin America illustrates points 1 and 2.

SUMMARY:
This talk will focus on community-based programs for people with psychoses. The first part will illustrate the challenges of developing and testing such programs in low- and middle-income countries, and discuss ways of addressing these challenges. The second part will discuss an example of adapting and testing a specific community-based program in middle-income countries of Latin America. This program has been adapted for urban areas of Latin America by REDEAMERICAS, a regional network funded by NIMH. It is currently being evaluated in a pilot (N-120) randomized controlled trial in three cities (Buenos Aires, Rio de Janeiro, Santiago). The purpose of the study is to lay the groundwork for doing full-scale regional trials and scaling up effective and feasible community-based programs.

LECTURE 13

OREGON'S HEALTHCARE TRANSFORMATION: LESSONS FOR THE NATION

Lecturer: David A Pollack, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the basic financing and delivery system elements of the Oregon and Federal (PPACA) health reform plans.; 2) Recognize the key barriers to effective health system reforms, as framed by the Triple Aim; 3) Become motivated to actively and positively participate in reforming the systems in their respective states.

SUMMARY:
Health system reform is definitely and finally happening in the United States. After more than a century of failed attempts to create a national health system, the Patient Protection and Affordable Care Act passed in 2010 and survived major Supreme Court challenges in 2012. Although a number of significant provisions of the bill have already been implemented, the first major and broadly recognized reforms will be implemented in October, 2013, with millions of newly insured consumers being enrolled to receive coverage in 2014. The success of PPACA depends, in large part, on how receptive and responsive the states are in adopting and implementing its major initiatives.

Oregon has a history of enacting progressive and innovative health reforms, beginning with the controversial and highly studied Oregon Health Plan (OHP) in 1989. Originally designed to provide universal access, but limited by legislative action, the OHP provided expanded access through Medicaid expansion and its innovative benefit design, predicated on explicit priority setting, aka "rationing".

More recently, in 2009, Oregon passed health reforms that anticipated and complement the PPAACA reforms. This presentation will review the history of the reforms in Oregon, beginning with the OHP, with particular emphasis on more recent efforts to create a universal access system that will, over time:

- provide coverage to most residents in the state, either through expansion of Medicaid or through the new Health Insurance Exchange (HIX),
- provide an essential benefit package (including mental health and substance use treatment services),
- integrate funding of all types of services through regional accountable care organizations,
- reconfigure the delivery system to create and emphasize the use of patient-centered primary care homes,
- integrate mental health and substance use services (and other relevant specialty services) with primary care homes,
- create alternative payment methods and allow flexible use of funds, and
- more effectively manage health care costs.

There are many instructive lessons that can be derived from Oregon's experience that may allow other states to develop effective and responsive health systems. This presentation and discussion will allow participants to compare their experiences and express concerns about how these reforms are emerging in their own states.

LECTURE 14

TOP 10 RECOVERY STRATEGIES THAT SHOULD BE INCLUDED IN MEDICAL HEALTH HOMES

Lecturer: Mark Ragins, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the need for and how to actively incorporate recovery into medical health homes; 2) Demonstrate knowledge of how to implement a set of 10 practice strategies and concomitant staff shifts that could benefit medical health homes; 3) Demonstrate knowledge of how those staff shifts help transform a clinic into a "home".

SUMMARY:
The creation of medical health homes is designed to transform our system into a coordinated, team based, primary care focused, prevention and wellness inclusive system of care. The world of recovery and severe mental illnesses has developed a number of strategies that should be included in this clinical transformation. Ever since deinstitutionalization we have been working to develop strategies to support complex, challenging people. With the emergence of the Recovery Movement the pace of innovation has accelerated. Now we're facing integration into medical health homes. What have we learned that we should try to bring to the table?

My "Top 10" list is:
1. ACT Teams
2. Integrating Substance Abuse Services
3. Building Protective Factors / Integrating Poverty Services
4. Case Management
5. Linking Treatment to Client-Driven Quality of Life Goals
6. Collaboration and Shared Decision Making
7. Self Help and Coping Skills / Building Self-Responsibility
8. Consumer and Peer Staff
9. Building Resilience, not Cure
10. Health and Wellness

Each of these strategies requires a shift in staff values and practice principles including individualization, acceptance, welcoming, shared responsibility, and empowerment. Taken together those staff shifts are what makes a "clinic" become a "home".

OCT 12, 2013

LECTURE 15

THE CHANGING FACE OF AUTISM

Lecturer: Fred R. Volkmar, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand current data on outcome in autism; 2) Specify at least three reasons why outcome might appear to be improving; 3) Identify core needs for support of adults with autism.

SUMMARY:
This presentation will summarize data on what appear to be major shifts (improvements) in outcome for individuals with autism and related conditions. This shift reflects a number of different factors including increased awareness, earlier identification, development of evidence based treatments, and so forth. The increased number of individuals with autism who are self-sufficient and independent as adults presents other challenges for the mental health system. Data on increased rates of anxiety and depression and of vocational and treatment supports needed will be summarized. Gaps in our knowledge, particular related to older adults, will be emphasized.

LECTURE 16

THE ROLE OF MENTAL HEALTH PROFESSIONALS IN THE EVALUATION AND TREATMENT OF VIOLENCE

Lecturer: Elissa P. Benedek, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the role of mental health professionals in evaluating violence; ; 2) Demonstrate knowledge of the role of mental health professionals indeveloping public policy related to violence; ; 3) Demonstrate knowledge of the role of mental health professionals in future research on the evaluation and treatment of violence.

SUMMARY:
Mental Health professionals have a significant role in preventing and reducing mortality and morbidity due to firearm -related violence. In honor of the contributions of Alexandra and Martin Symonds to reducing unnecessary and preventable violence this lecture will focus on reasonable roles available to mental heath professional including the initial evaluation interview and, treatment, of children adolescents and their families.In addition to the evaluation and treatment roles of the individual mental heath professional the role of professional organizations in supporting national and state legislative and regulatory actions will be discussed. Research and training on the causes and prevention of violence should be and organizational and national priority.

LECTURE 17

THE CHANGING PATTERN OF MENTAL DISORDERS IN CHINA AND OTHER ASIAN COUNTRIES

Lecturer: Michael R. Phillips, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize major differences in the prevalence and characteristic of mental disorders in China and other Asian countries compared to the US and other high-income countries; 2) Understand how rapid urbanization and socioeconomic development in Asia has changed the perception and management of psychiatric conditions and suicide.

SUMMARY:
The rapid socioeconomic transformation of China, India and other Asian countries over the last 20-30 years has had a dramatic effect on the perception and management of mental disorders in the region. There is substantial diversity both between and within countries in the region, but the Asia-wide reduction in the relative importance of infectious diseases has resulted in a much greater emphasis on chronic, disabling health conditions, including psychiatric disorders. Rapid urbanization, a rising middle class, the aging of the population, and the internet-induced global homogenization of both professional and lay perceptions of psychological problems is changing the types and characteristics of mental disorders identified by societies, the demand for mental health services, and the range and types of services provided in different communities. The interplay of these many forces is, perhaps, most clearly evident in the dynamic Asian region.

This lecture will use data from the Global Burden of Diseases study, the WHO World Mental Health Survey and other sources to compare and contrast the profiles of psychiatric disorders between low- and middle-income countries in Asia with those of the US and other high-income countries. Changes over time in the reported prevalence of mental, neurological and substance abuse disorders in China, India and other Asian countries -- particularly, suicide, alcohol abuse and dementia -- will be discussed in light of the ongoing social changes in the region. Legislative and programmatic efforts to address these problems in Asia will be compared by considering the comprehensive regulations included in the new mental health law recently enacted in China and the proposed new mental health law in India. The talk will conclude with a discussion of areas where findings from Asia challenge conventional wisdom about the definitions, characteristics and appropriate management of mental health disorders in high-income countries.

NEW RESEARCH POSTERS

THURDSDAY, OCTOBER 10, 2013

POSTER SESSION 1

P1-01
RECHALLENGING CLOZAPINE AFTER NEUROLEPTIC MALIGNANT SYNDROME

Lead Author: Emaya Anbalagan, M.D.

Co-Author(s): Naveen Yarasi, M.D; Muaid Ithman M.D.

ABSTRACT:
Introduction: Neuroleptic malignant syndrome (NMS) is a potentially fatal manifestation of antipsychotic use associated with symptoms like mental status changes, muscle rigidity, fever and autonomic dysfunction. It is known to be associated more with typical antipsychotics but atypical antipsychotics like Clozapine are not exempt from this side effect. Clozapine is one of the most effective antipsychotics for refractory schizophrenia, but when patients develop life threatening adverse effects like NMS, treatment options become limited. Here we present a case of a patient who developed typical symptoms of NMS with Clozapine and was rechallenged with Clozapine successfully.

Case Summary: The patient was a 24 year old female with a diagnosis of schizoaffective disorder, bipolar type, who presented with paranoia, auditory command hallucinations and bizarre behavior. She was tried on three antipsychotics and three mood stabilizers which included Paliperidone. However she did not show improvement and her behavior continued to be disorganized, including but not limited to drinking out of the toilet bowl, taking several cold showers daily and having auditory hallucinations. Clozapine was started and titrated upwards. Five days after commencing Clozapine, at a dose of 100mg, she developed typical NMS features including muscular rigidity, fever, mental status changes, elevated Creatine Kinase (CK - 3078 U/L), leukocytosis and urinary incontinence. Of note is that the patient was on Lithium concomitantly. She was transferred to the medical service, treated with IV hydration and her psychotropic medications were stopped. The patient was re-admitted to psychiatric unit after her NMS symptoms resolved and she was medically stabilized. No psychotropic medications were started for two weeks and then clozapine was rechallenged at a low dose of 25 mg at bedtime and titrated upwards slowly over a period of 10 days to 200mg daily totally. Her symptoms improved and she was at her baseline on discharge after an inpatient stay of almost 4 months totally.

Discussion: A review of literature revealed only 5 reports (1991 - 2001) of patients who had developed typical NMS with Clozapine who were rechallenged with the drug after an average time of 8.5 weeks. In consensus patients who develop NMS with Clozapine can be rechallenged after a reasonable period of time; 2 weeks in our patient. Concomitant use of Lithium has been shown to be associated with increased neurotoxic effects. Rechallenge is usually successful if care is taken to avoid concurrent use of Lithium and other psychotropics, dosing by starting at low doses and titrating upwards slowly while monitoring closely for emerging NMS symptoms. Serial CK levels can be adopted for more close monitoring. Although NMS with Clozapine is rare, physicians should be aware that emergence of NMS should not be a deterrent to rechallenging the drug again, provided slow careful dose titration is done.

P1-02
LITHIUM, HYPERCALCEMIA, AND HYPERPARATHYROIDISM: WHAT PSYCHIATRISTS NEED TO KNOW

Lead Author: Emaya Anbalagan, M.D.

Co-Author(s): Anupama Ramalingam MD,

ABSTRACT:
Introduction: Lithium has been known to cause varied side effects like leucocytosis, hypothyroidism, weight gain, renal abnormalities including diabetes insipidus and cardiac arrhythmias which are very well known. One adverse effect which is not so much in the forefront in psychiatry is hypercalcemia and sometimes associated hyperparathyroidism. Here, we present a patient who presented with lithium toxicity, altered mental status, hypercalcemia, hyperparathyroidism and also nephrogenic diabetes insipidus with a specific focus on what psychiatrists need to know in managing hypercalcemia and hyperparathyroidism.

Case report: Mrs. A was a 66 year old Caucasian female with a history of schizoaffective disorder. She was admitted for altered mental status from an outside hospital due to Lithium toxicity. Her lithium level was reported to be 3.4mEq/L initially but was around 1mEq/L on admission. She was found to be in acute renal failure with hypernatremia and hyperthyroidism and was diagnosed with Lithium induced Nephrogenic Insipidus. iCal was critically high at 1.62mmol/L, total Calcium was 11.2 mg/dl. She was aggressively treated with free water replacement and DDAVP. Lithium was stopped. Further evaluation revealed a high PTH of 484.8pg/ml (normal 15 - 65 pg/ml). In a few days, her mentation improved. Nephrology recommended starting cinacalcet 30 mg daily. A Sestamibi scan did not show definite evidence of Parathyroid adenoma but was limited due to patient noncompliance. At this point iCal was 1.54mmol/L and the total calcium was down to 10.0mg. She had also been given one dose of IV zoledronic acid. Once the patient had been medically stabilized and her mental status had improved, she was discharged home on cinacalcet 30 mg bid to follow up with nephrology and the medical team.

Conclusion: Lithium has been known to cause hypercalcemia by altering the set point of calcium sensing receptors. Hypercalcemia and hyperparathyroidism have been seen in 10-15 % of people on long term lithium in some studies. Stopping lithium may reverse this but if hypercalcemia persists many options exist - careful observation alone, treatment with cinacalcet or parathyroidectomy in patients with parathyroid adenomas. The importance in treating this lies in the fact that many patients whose psychiatric symptoms were not under control reported symptomatic improvement once their endocrine irregularities were corrected. Prior to starting Lithium, baseline PTH and calcium levels should be established. No standard recommendations exist but some authors suggest that the levels be checked atleast on a yearly basis and sooner in patients showing symptoms of hypercalcemia - fatigue, constipation, polydipsia, polyuria, muscle weakness and altered mental status. Psychiatrists have to be aware of hypercalcemia and hyperparathyroidism as a side effect of Lithium use and should incorporate screening and regular checks of parathyroid function as part of their treatment.

P1-03
COMBINATION OF FLUOXETINE AND NALTREXONE: AN EFFECTIVE TREATMENT OF PARAPHILIAS

Lead Author: Shanel Chandra, M.D.

Co-Author(s): Yasir Ahmad, M.D., Anbreen Khizar, M.D.

ABSTRACT:
Paraphilias can be defined as a disease spectrum consisting of sexual fantasies, urges or behaviors involving non-human objects and non-consenting humans and requires both intensive psychological and pharmacological treatment. Persons who comes in for psychiatric treatment usually comes in due to court mandated psychiatric evaluation, as with our case presented below. As paraphilias involves both obsessions and compulsions, it is most of the times treated as an OCD, cognitive behavior therapy playing a major role. Many studies have shown effectiveness of Fluoxetine in Obsessive compulsive disorder . We present a case of a 77 yr old male with past psych history of impulse control, specifically paraphilia who came in for psych evaluation after being arrested for exposing himself naked to a woman. He had had these obsessive thoughts of exposing himself in a sexually inappropriate way to women along with an urge to rub himself against women in buses since he was 14 yrs of age, with multiple detentions for the same. Patient was given AXIS-1 diagnosis of Exhibitionism, Frotteurism, Voyeurism, sexually attracted to females and was started on naltrexone 50mg daily, with fluoxetine being having been started at 10mg and finally increased to 40 mg daily over next few visits.The patient reported that his socially inappropriate urges had decreased and the patient has had no recurrence till date. The patient was still masturbating about 3 times/week. This report shows the effectiveness of high dose of fluoxetine with adjuvant Naltrexone in treating paraphilias with selectivity towards pathological sexual urges and preservation of natural sexual desires. Discussion further needs exploring the role of serotonin in sexual paraphilias and using other adjuvant treatment modalities with Fluoxetine being a part of the initial treatment regimen.

P1-04
PRIAPISM: AN IDIOSYNCRATIC RESPONSE TO ATYPICAL ANTIPSYCHOTICS

Lead Author: Jaimini Chauhan-James, M.D.

ABSTRACT:
Priapism has been described as prolonged, usually painful, and persistent penile erection not associated with sexual stimuli, resulting from a disturbance in the normal regulatory mechanisms that initiate and maintain penile flaccidity (1). It is an infrequent adverse event that requires emergency evaluation and has the potentially of serious long-term consequences, including erectile dysfunction due to ischemia and fibrosis of the corpora cavernosa and gangrene (2, 3, 4). A variety of etiologic factors are implicated in this condition. Non Ischemic priapism is associated with penile or perineal trauma, cocaine,(5,6,7,8) marijuana,(16,6,8) metastatic malignancy, whereas ischemic priapism is associated with hematologic disorders, metabolic disorders, alcohol, antidepressants and antihypertensive medications (5,7,8,11,15,16).

P1-05
ROUTINE METFORMIN USE FOR SECONDARY PREVENTION OF ANTIPSYCHOTIC-INDUCED WEIGHT GAIN IN PATIENTS WITH SCHIZOPHRENIA: REAL-WORLD CLINICAL EXPERIENCE

Lead Author: Stephanie Cincotta, M.D.

Co-Author(s): Hannah E Brown, Sarah A MacLaurin, David C Henderson, Oliver Freudenreich

ABSTRACT:
Background: Weight gain associated with the use of second-generation antipsychotics (SGAs) increases the risk of both type II diabetes mellitus and cardiovascular disease. There has been considerable interest in identifying interventions, both pharmacologic and non-pharmacologic, to minimize the rate of weight gain in this population as a means of secondary prevention.

Objective: To determine whether the addition of metformin

has been associated with weight loss among patients with schizophrenia treated with SGAs in an outpatient clinic.

Methods: Weight and metabolic data were gathered retrospectively from charts of patients in the MGH Schizophrenia Program who had a diagnosis of schizophrenia; were prescribed at least one SGA; were prescribed metformin for weight-related concerns; and did not have a diagnosis of diabetes.

Results: 20 patients were identified as meeting inclusion criteria among 586 charts reviewed (3.4%). Average duration of current antipsychotic therapy was 1.9 ± 3.1 years upon initiation of treatment with metformin. Patients were obese with a mean BMI of 32.9 ± 4.1 kg/m2. Duration of treatment with metformin averaged 431.3 ± 439.3 days. Use of metformin was associated with significant weight loss in a minority of patients (N=6; loss averaged 22.2 ± 14.9 lbs; 95% CI 6.6 to 37.8; p=0.014), however overall there was no clinically significant weight loss (0.71 ± 19.4 lbs; 95% CI -8.9 to 10.4; p=0.878). Metformin was generally well-tolerated apart from GI distress in 30% of patients.

Conclusions: Metformin use was not associated with significant weight loss in a small sample of patients prescribed SGAs, however further data are needed to elucidate factors contributing to significant and clinically meaningful weight loss in a minority of patients.

P1-06
A CURRENT REVIEW OF CYTOCHROME P450 INTERACTIONS OF PSYCHOTROPIC DRUGS

Lead Author: U Velama, M.D.

Co-Author(s): Umamahesh Velama M.D; Jeniel Parmar Ph.D; Diana Goia M.D; Ronald Brenner M.D

ABSTRACT:
Introduction/Hypothesis: Majority of psychotropic agents are biotransformed by hepatic enzymes which can lead to significant drug-drug interactions. Most drug-drug interactions of psychotropic drugs occur at metabolic level involving the cytochrome P450 system. Concomitant administration of multiple medications that induce; inhibit or are substrates of the major CYP 450s can cause changes in plasma levels of the drugs leading to unexpected side effects or suboptimal efficacy. CYP inhibition can reduce the metabolism of a given drug leading to increased levels and serious adverse effects. CYP induction can cause increased metabolism leading to reduced plasma drug levels and suboptimal efficacy. Psychotropic drugs may interact with other prescribed drugs for medical conditions, over the counter drugs, herbal products, dietary supplements and certain food items.

Methods: We searched the U.S National Library of Medicine, Psych Info and Cochrane reviews from 1981 to 2012. Search was limited to English language terms, psychotropic drugs, CYP 450s and drug interactions.

Results: A total of 1593 citations were retrieved. We reviewed clinical trials, double blind placebo controlled studies, randomized controlled trials, case reports and review articles. Results indicated that majority of serious drug-drug interactions are caused by inhibition of CYP 450s by various endogenous and exogenous compounds.

Conclusion/Discussion: Pharmacogenetic studies of genetic mutations like single nucleotide polymorphisms (SNP), copy number variabilities (CNV) and differences in ethnicity leading to ultra rapid metabolizers (UM) and poor metabolizers (PM) are of paramount importance in the assessments. A thorough knowledge of psychiatric disorders, mechanism of action of drugs and role of CYP 450 are key to optimal care. Patients should be educated to keep a list of all prescribed medications, OTC drugs and dietary supplements and present it to all the physicians involved in their care. Electronic databases will largely facilitate the retrieval of information and appropriate drug therapy.

P1-07
TREATMENT OF AN INDIVIDUAL WITH TRAUMATIC BRAIN INJURY AND SUBSEQUENT EMOTIONAL VOLATILITY WITH DEXTROMETHORPHAN/QUINIDINE

Lead Author: Tom Johnson, M.D.

Co-Author(s): Wagner, Joyce, PA-C; Geers, Michelle;Shen, Joann LCDR; Garcia-Baran, Dynela, MD

SUMMARY:
Pathological laughing and crying, or pseudobulbar affect (PBA), has been described in patients with several neurological disorders, including traumatic brain injury (TBI). It is an under diagnosed condition characterized by inappropriate, uncontrollable episodes of laughing or crying after minor stimuli. These outbursts are embarrassing or unpleasant for the individual, and impair social and occupational function. Dextromethorphan/Quinidine (Nuedexta) has been shown to benefit patients with PBA due to amyotrophic lateral sclerosis, multiple sclerosis, and a variety of other neurological conditions.

We present a case of an individual who was assaulted and suffered a TBI. He has little memory of events around the time of the assault, but subsequent to the assault was able to return to a high level of function at home and at work. However, he did develop headaches, problems with memory, sleep, and changes in mood and affect, including outbursts of laughing and crying that had not happened before the assault and were embarrassing for him. Otherwise his neurological examination was essentially unremarkable. An MRI of the brain revealed an area of increased signal in the right frontal cortex that is consistent with a lesion resulting from a TBI. He was treated with a variety of standard medications and participated in cognitive, vestibular, and occupational health rehabilitation. In addition, he was started on Neudexta and reported that the Neudexta resulted in an improvement in his symptoms.

There is no evidence of that this individual suffered any harm from the use of Neudexta. He did report improvement in his symptoms with the medication, although it is not clear if his clinical improvement is due exclusively to the Neudexta. Further study is needed to evaluate individuals with changes in affect consistent with PBA after a TBI, particularly individuals who function at a high level and may have changes in mood and affect that are categorized as emotional volatility, depression, or PTSD and the diagnosis of PBA is not a part of the differential diagnosis and the use of Neudexta is not considered.

P1-08
SEVERE FACIAL DISFIGURATION IS ASSOCIATED WITH HIGH RATES OF PSYCHOPATHOLOGY: PRELIMINARY FINDINGS

Lead Author: Aris Hadjinicolaou

Co-Author: Yael Wolf, M.D.

SUMMARY:
Title: Severe facial disfiguration is associated with high rates of psychopathology: preliminary findings

Introduction: Severe facial disfiguration irrespective of etiology is associated with emotional, social and behavioral problems. Facial transplantation has recently emerged as an option for patients with disfiguration which had not been correctable by previous conventional reconstructive surgery. Given the risks associated with facial transplantation, the psychiatric correlates and impairment caused by the disfiguration need to be investigated. The aim of this study is to conduct a comprehensive psychosocial and quality of life evaluation of severely disfigured patients, with the ultimate goal to better address the psychological and psychiatric needs of this population.

Methods: This study is a cross-sectional case-control study. All patients aged 18 or older reconstructed for major disfigurement between 2007-2010 at one hospital center by a single surgeon were approached for recruitment. Major disfigurement was defined as being at least 30% of the facial surface area or two facial aesthetic subunits. Controls were defined as patients who had same etiology of disfiguration (tumor, burn, etc.), but whose disfiguration did not affect the face.

Participants were administered self-report questionnaires assessing socio-demographic data, quality of life (SF-36, EORTC), anxiety (SPIN, PSWQ PD screen), depression (BDI), substance use (ASSIST, DAST), self-esteem (Rosenberg), body image (MBSRQ, SIBID), suicidality, social support, coping styles and facial appearance-related distress.

Results: Preliminary data analysis of 12 facially disfigured patients indicates that despite conventional reconstructive surgery, 67% of the patients are dissatisfied with their facial appearance. 64% of the patients consider themselves at least moderately disfigured and 55% of the patients are at least moderately distressed by their facial appearance. 25% of the subjects had poor self-esteem. 33% of the subjects had at least moderate social phobia. 33% of the subjects had at least moderate depressive symptoms. “Emotional coping” (guilt/self-blame coping), inadequate social support and lack of significant other were all factors associated with depression and social phobia.

Conclusion: Facial disfiguration has negative effects on mental health, with a third of subjects suffering from depressive symptoms and a third suffering from social phobia. Data analysis of the second phase of this study, which will include assessment of controls, is currently underway and will serve to expand upon these preliminary analyses.

P1-09
METHYLPHENIDATE HYDROCHLORIDE MODIFIED RELEASE (MPH-LA) IN ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD): OVERALL CLINICAL IMPROVEMENT

Lead Author: Daniel Gruener, M.D.

Co-Author(s): M. Huss; Y. Ginsberg; A. Philipsen; T. Tvedten; T. Arngrim; M. Greenbaum; K. Carter; CW. Chen; V. Kumar

ABSTRACT:
Introduction: MPH-LA is clinically effective and well tolerated in children with ADHD. Overall clinical improvement in adult ADHD was evaluated as secondary objective in this 40-week, randomized, double-blind, placebo-controlled, multicenter study.

Objectives: Overall improvement of patients on the Clinical Global Impression-Improvement (CGI-I) scale at the end of the 9-week fixed-dose treatment period (TP1) vs placebo; Objective 2: Overall improvement of patients on Clinical Global Impression-Severity (CGI-S) scale at the end of TP1; Objective 3: Tolerability of MPH-LA vs placebo.

Methods: The study consisted of three treatment periods (TP). In the 9-week double- blind, parallel-group TP1, 725 patients were randomized (1:1:1:1) to receive MPH-LA 40,

60, or 80 mg/day or placebo qd (3-week titration, 6 weeks fixed dose). TP2 was an open-label 5-week titration period to individual optimal dose. During TP3, patients were re-randomized (3:1) to their optimal dose or placebo in a 6-month double- blind withdrawal period. Overall clinical improvement at the end of TP1 was measured on the CGI-I scale. Improvement on the CGI-I scale was defined as a visit rating of 1, very much improved or 2, much improved. Other secondary efficacy endpoints were improvement of CGI-S, defined on a 7-point scale as a decrease in the CGI-S rating scale at the end of TP1 and tolerability. Proportion of patients with clinical improvement on the CGI-I and CGI-S scales were analyzed using a logistic regression model.

Results: 863 patients were screened and 725 randomized to 40 (N=181) 60 (N=182), or 80 mg (N=181) MPH-LA and placebo (N=181) in TP1. 56.3%, 54.8%, and 57.1% patients treated with 40, 60 or 80 mg MPH-LA, showed overall improvement from baseline on the CGI-I scale vs 31.7% of patients treated with placebo. Odds ratios [95%CI] MPH-LA vs placebo were 2.44 [1.52, 3.93], p=0.0002; 2.25 [1.40, 3.64], p=0.0009; 2.51 [1.56, 4.05], p=0.0002 for 40 mg, 60 mg and 80 mg MPH-LA. 71.3% 73.7% and 74.2% of patients treated with 40, 60 and 80 mg MPH-LA showed improvement on the CGI-S compared with 48.4% on placebo (odds-ratio [95%CI] = 2.79 [1.73, 4.48]; 3.20 [1.97, 5.22]; 3.24 [1.98, 5.28] for MPH-LA 40, 60, and 80 mg (p<0.0001 for all comparisons). 72.8%, 74.0 % and 75.1% of patients treated with 40, 60 and 80 mg MPH-LA compared with 60.0% on placebo reported adverse events (AEs) in TP1. Serious adverse events (SAEs) in TP1 were reported in 0.6%, 1.1%, 0.6 % in MPH-LA 40, 60 and 80 mg vs 1.1% on placebo, 0.4% of all MPH-LA treated patients vs 0% on placebo reported clinically notable changes in systolic and diastolic blood pressure.

Conclusions: Adult ADHD patients treated with MPH-LA 40–80 mg show superior clinical improvement compared with placebo assessed on CGI-I and CGI-S scales. The safety and tolerability results were consistent with the established safety profile for MPH-LA. No unexpected AEs and SAEs were observed in adult ADHD patients.

P1-10
QTC PROLONGATION AND ARRHYTHMIA RISK IN VETERANS WITH OPIATE DEPENDENCE ON METHADONE MAINTENANCE TREATMENT

Lead Author: Sameer Hassamal, M.D.

Co-Author(s): Antony Fernandez, M.D.; Ananda K. Pandurangi, M.D.; W. Victor R. Vieweg, M.D.; Hossein Moradi Rekabdarkolaee, MS

ABSTRACT:
Objective: Methadone, an opiate used in the treatment of opiate dependence, prolongs the rate- corrected QT interval (QTc) and may result in torsade de pointes (TdP). Multiple studies have shown that a rate-corrected QT interval (QTc) of > 500 milliseconds (msec) is a significant risk factor for TdP. However, regulatory guidelines suggest a sex-independent threshold for QTc prolongation of 450 msec. In this retrospective study, the QTc was compared before and after a stable dosage of methadone had been initiated in a veteran population to treat opiate dependence. In addition, the most up-to-date clinical risk factors for QTc prolongation were correlated with the most recent QTc once the veteran had been put on a stable dose of methadone.

Methods: Data from a standard 12-lead electrocardiogram and clinical risk factor data were retrospectively collected by chart review.

Results: Of the 49 veterans included in the study, 47 were male, 38 (78%) were African American, and 11 (22%) were Caucasian. A total of 32 (65%) were unemployed. The mean age was 56.90±6.48 years. The mean dose of methadone prescribed was 78.20 mg/day±25.30 mg/day. The mean QTc was higher on a stable dose of methadone (450.53±34.56 msec) than before treatment (425.40±34.53 msec). A paired sample test showed that the QTc was significantly longer after initiating methadone treatment (t=-4.62, df 46, p=0.00). On a stable dose of methadone, 26 of the veterans (53%) showed a QTc ?450 msec, and 23 (47%) displayed a QTc > 450 msec. The average heart rate was 70±12.89 beats per minute (bpm). 44 (90%) had a substance use disorder; 36 (74%) had a psychiatric disorder; 24 (49%) were on antidepressants; and 4 (8%) were on antipsychotics. 6 (12%) exhibited hypokalemia, 10 (20%) hypomagnesaemia and 1 (2%) hypophosphatemia. With respect to comorbid conditions, 26 (53%) had liver disease, and 8 (16%) had cardiac disease. No significant relationships were found between QTc prolongation and methadone dosage, age, electrolytes, cardiovascular disease, elevated liver transaminases, gender, or the use of antidepressant or antipsychotic medication. Of the 53% of veterans who displayed a QTc of greater than 450 msec, none experienced fatal arrhythmia.

Conclusion: The low power of the study and the low prevalence and complexity of medical co-morbidities may explain the lack of a significant correlation between any risk factor, either individually or as a group, with the QTc. The absence of TdP can be explained by the low prevalence of QTc values greater than 500 msec.

References:

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P1-11
PHARMACOTHERAPY OF HOMELESS VETERANS IN THE VETERANS HEALTH ADMINISTRATION

Lead Author: Eric D.A. Hermes, M.D.

Co-Author(s): Robert Rosenheck, M.D.

ABSTRACT:
Objectives: No prior studies have directly investigated the psychopharmacology associated with homelessness. This study evaluated differences in psychotropic medication use between homeless and domiciled individuals with serious mental illnesses where pharmacologic management is indicated.

Methods: All veterans using Veterans Health Administration (VHA) services in 2010 and diagnosed with a serious mental illness were evaluated using national administrative data. Homelessness was defined as receipt of a homeless diagnostic code or homeless services in 2010. Bivariate correlates of homelessness were identified. The adjusted mean number of psychotropic prescriptions associated with homelessness was identified using regression models adjusted for potentially confounding variables including the use of residential or inpatient services.

Results: Of the 876,989 individuals given a serious mental illness diagnosis, 62,899 (7.2%) were homeless at some time during 2010. In unadjusted analyses, all psychotropic medications, excluding sedative hypnotics, were prescribed in greater numbers to homeless individuals. However, after adjusting for important sociodemographic, diagnostic, outpatient service, and residential treatment variables, fewer psychotropic medications were prescribed to homeless compared to domiciled individuals for all medication types except opiates. When all psychotropic were considered together in adjusted analysis, domiciled individuals received 16.2% more prescriptions (F=6947.1, p<0.001). In adjusted analyses controlling for the interaction between residential treatment use and homelessness, individuals in residential treatment received more prescriptions of any psychotropic except stimulants and opiates among both homeless and domiciled individuals.

Conclusion. Homelessness is associated with the receipt of moderately fewer psychotropic prescriptions, net of the presence of important sociodemographic, diagnostic, service use, and residential treatment factors.

P1-12
SWITCHING FROM RISPERIDONE, OLANZAPINE, OR ARIPIPRAZOLE TO ILOPERIDONE IN PATIENTS WITH SCHIZOPHRENIA: DOES SOMNOLENCE/SEDATION AS A REASON FOR SWITCH AFFECT CLINICAL OUTCOMES AND TOLERABILITY?

Lead Author: Richard Jackson, M.D.

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ABSTRACT:
Background: Clinically relevant somnolence/sedation is a commonly encountered side effect of many antipsychotic medications and may trigger a switch in treatment. In the iloperidone Flexible-dose Study Assessing Efficacy and Safety and Tolerability of Two Switch Approaches in Schizophrenia Patients (i-FANS), adults with schizophrenia exhibiting suboptimal efficacy and/or safety/tolerability were switched either immediately or gradually from their current antipsychotic treatment of risperidone, olanzapine, or aripiprazole to iloperidone 12–24 mg/d. Clinical outcomes and tolerability of iloperidone treatment in the subgroup of patients who switched from their prior treatment due to somnolence/sedation are discussed.

Methods: Among inclusion criteria, subjects were required to be prescribed risperidone, olanzapine, or aripiprazole as maintenance therapy and continue to have persistent symptoms or tolerability problems. Subjects in this 12-week open-label study were randomized to 1 of 2 switch strategies: a gradual taper of their prior antipsychotic dose over a 2-week cross-taper period or an immediate switch. The primary variable was the Integrated Clinical Global Impression of Change (I-CGI-C); primary analysis time point was at Week 12. The somnolence subgroup was assessed by I-CGI-C, Safety and Tolerability CGI-S (ST-CGI-S), somnolence adverse events (AEs), and discontinuations due to somnolence.

Results: Of the 500 randomized subjects, 53 (10.6%) switched primarily due to somnolence/sedation (gradual switch, 26; immediate switch, 27). Among these patients, least-squares mean (LSM) I-CGI-C score (1 [very much improved] to 7 [very much worse]) at Week 12 was 2.88 for the gradual- and 2.41 for the immediate-switch group. LSM change scores for the ST-CGI-S (1 [normal, no symptoms] to 7 [among the most extreme]) were -1.42 and -1.72, demonstrating an improvement from baseline (mean baseline score: 3.7 and 3.9). The most commonly reported AEs were dizziness (9/26 patients) and dry mouth and headache (both 5/26) in the gradual-switch group and dizziness (7/27) and dry mouth and somnolence (both 5/27) in the immediate-switch group. Somnolence was reported as an AE by a total of 8/53 (15.1%) patients (gradual-switch,

n=3/26; immediate-switch, n=5/27) and 1 patient (immediate-switch group) discontinued due to somnolence in this subgroup.

Conclusion: In patients who switched from their prior treatment due to somnolence/sedation, efficacy rating improvements and a positive safety/tolerability profile were observed upon switching either gradually or immediately to iloperidone. Somnolence was reported by 15% of patients within this subgroup over the 12 weeks of iloperidone treatment. This study was funded by Novartis Pharmaceuticals Corporation.

P1-13
SWITCHING FROM RISPERIDONE, OLANZAPINE, OR ARIPIPRAZOLE TO ILOPERIDONE IN PATIENTS WITH SCHIZOPHRENIA: DOES WEIGHT GAIN AS A REASON FOR SWITCH AFFECT CLINICAL OUTCOMES AND TOLERABILITY?

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ABSTRACT:

Background: Patients with schizophrenia often change antipsychotics due to tolerability issues, with weight gain a common reason for switching. In the iloperidone Flexible-dose Study Assessing Efficacy and Safety and Tolerability of Two Switch Approaches in Schizophrenia Patients (i-FANS), adults with schizophrenia exhibiting suboptimal efficacy and/or safety/tolerability were switched either immediately or gradually from their current antipsychotic treatment of risperidone, olanzapine, or aripiprazole to iloperidone 12-24 mg/d. This report focuses on the subgroup of patients who switched to iloperidone primarily because of weight gain concerns.

Methods: Among inclusion criteria, subjects had to be prescribed risperidone, olanzapine, or aripiprazole as maintenance therapy and continue to have persistent symptoms or tolerability problems. Subjects in this 12-week open-label study were randomized to 1 of 2 switch strategies: gradual taper of their prior antipsychotic dose over a 2-week cross-taper period or immediate switch. Primary variable was the Integrated Clinical Global Impression of Change (I-CGI-C); primary analysis time point was at Week 12. The weight gain subgroup was assessed by I-CGI-C, Efficacy CGI of Severity (E-CGI-S), weight gain adverse events (AEs), and discontinuations due to weight gain.

Results: Of the 500 randomized subjects, 77 (15.4%) switched due to weight gain (gradual switch, 35; immediate switch, 42). Mean (SD) weight and body mass index at baseline were 101.3 (27.9) kg and 34.3 (7.7) kg/m2 for the gradual- and 101.8 (25.3) kg and 35.1 (10.8) kg/m2 for the immediate-switch group. Among these patients, least-squares mean (LSM) I-CGI-C score (1 [very much improved] to 7 [very much worse]) at Week 12 was 3.08 for the gradual- and 2.64 for the immediate-switch group. LSM change from baseline to Week 12 scores on the E-CGI-S (1 [not at all ill] to 7 [among the most extremely ill]) improved by -0.55 and -0.80 for the gradual- and immediate-switch groups, resp., (mean baseline scores: 3.7 and 3.6). The most commonly reported AEs were somnolence (6/35 patients) and insomnia and dry mouth (both 5/35) in the gradual-switch group and dizziness and insomnia (both 8/42) and nausea (7/42) in the immediate-switch group. Weight gain was reported as an AE by 2/77 patients (gradual-switch, n=1/35; immediate-switch, n=1/42) and no patients discontinued due to weight gain in this subgroup. Mean (SD) weight gain from baseline to Week 12 was 0.7 (2.9) kg and 0.4 (3.7) kg, resp., and 1/35 (2.9%) and 2/41 (4.8%) patients experienced weight gain (7%).

Conclusion: In patients switching to iloperidone from prior treatment due to weight gain, although efficacy and safety/tolerability ratings did not differ between switch groups and showed improvements, patients' weight exhibited negligible change from baseline, with no discontinuations and 3/76 (3.9%) experiencing weight gain ?7% from baseline. Study funded by Novartis Pharmaceuticals Corp.

P1-14
DOES ETHNICITY AFFECT CLINICAL OUTCOMES AND TOLERABILITY IN PATIENTS WITH SCHIZOPHRENIA WHO SWITCH TO ILOPERIDONE?

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ABSTRACT:

Introduction: Substance abuse is a pattern of maladaptive behavior that culminates in various adverse outcomes. Currently, the prevalence of substance abuse is soaring nationwide requiring that psychiatric emergency physicians be well versed in the diagnosis and treatment of substance abuse. Previous literature has clearly identified poorer patient outcomes in substance abusers with psychiatric comorbidities. However, despite growing ethnic diversity, a paucity of research exists on how ethnicity/race influences substance abusers seeking psychiatric emergency services (PES). The significance of this research scarcity becomes more apparent when evaluating U.S. Census publications which attribute 55% of the population growth (from 2000-2010) to Latinos. This research evaluated the differences among Caucasian and Latino substance abusers utilizing PES.

Methods: We conducted a retrospective study which utilized a PES database from a California county of 780,000 inhabitants. Over a ten month period, 2080 PES evaluations were examined and there were 163 evaluations with a primary discharge diagnosis of substance abuse/dependence. These evaluations were then dichotomized into Caucasian and Latino subgroups, as other ethnic groups were too small to ensure a statistical meaningful analysis. T-test and Chi-square analysis were used for continuous and categorical data, respectively.

Results: The sample consisted of 69.4% (100) Caucasians and 30.6% (44) Latinos with respective mean ages ± SD of 40.3 ± 13.2 and 32.9 ± 10.5 (t=3.27, df= 142, p= .001). Comparing Caucasian and Latino subgroups, respectively, there were 55% (55) versus 77% (34) males ($?^2$=6.42, df= 1, p=.011); 16% (16) versus 14% (6) were married ($?^2$= 0.13, df= 1, p= .717); 56% (56) versus 73% (32) were without insurance ($?^2$= 3.60, df= 1, p= .058). Furthermore, 77% (77) versus 77% (34) were admitted to PES on an involuntary hold ($?^2$=.0013, df=1, p=.971); 57% (57) versus 57% (25) had their hold initiated because they were identified as a danger to self ($?^2$=.0004, df=1, p=.984); 18% (18) versus 30% (13) were identified as a danger to others ($?^2$=2.41, df=1, p=.121). Lastly, there were no differences for PES disposition ($?^2$=2.34, df=1, p=.126).

Conclusion: This study indicates that Latinos diagnosed with substance abuse disorders in the psychiatric emergency setting were significantly younger and more frequently male. The study also suggests that insurance status is likely to play a role. Yet, little is known about how these discrepancies are affecting clinical outcomes and future research should be done to improve the quality of PES care.

P1-15
ANTIPSYCHOTIC ESCALATION IN A PATIENT WITH A HISTORY OF CATATONIA AND DEHYDRATION CAUSING NEUROLEPTIC MALIGNANT SYNDROME

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ABSTRACT:

Introduction: Neuroleptic Malignant Syndrome (NMS) is a rare, but potentially lethal complication of antipsychotic medications. We illustrate here story of a young man presenting with rather benign symptomatology that evolved into a critical diagnosis, but was resolved with appropriate interventions.

Case: A 20-years old Hispanic man was admitted o inpatient psychiatry for acute paranoia and psychosis. Past psychiatric history included schizoaffective disorder. He was on fluphenazine decanoate at home. On day 2, patient was noted to be lethargic with change in mental status. He was also noted to be febrile (102 F), and rigid. Neuroleptic Malignant Syndrome (NMS) was suspected. Emergent labs revealed WBC of 12,700/ml, and CPK of 5336 IU/L. Basic metabolic panel revealed relative dehydration (Sodium 139, Calcium 10.3, and Albumin 5.3). Patient was immediately transferred to medical floor for NMS management. Treatment with normal saline infusion, intravenous bromocriptine and lorazepam was initiated. CPK level worsened to 11012 IU/L next day. Fever and rigidity eventually subsided on day 5, and CPK slowly trended down to 394 IU/L. After six days of medical management, NMS was resolved. Patient was transferred back to psychiatry for treatment of severe paranoia and psychosis. Search for etiology revealed the following: he was recently discharged after being treated in the medical and psychiatry inpatient units for dehydration and schizoaffective disorder. Of note, he had 3 admissions to medical service within the last year for dehydration; his last discharge diagnosis included catatonia. He was maintained on fluphenazine since 2 years after having failed asenapine, sertraline, valproic acid and lithium. Fluphenazine was changed to depot form 1 month ago due to non-compliance, and the dose was increased from 25 mg to 37.5 mg two weeks ago.

Discussion: Neuroleptic Malignant Syndrome is seen in 0.07 - 0.2% of patients taking antipsychotic drugs. It is more commonly associated with high-potency typical antipsychotics, but can be seen with any antipsychotic medication. Most cases develop soon after initiation of therapy, or with a rapid change of dosing. There are suggestions in the literature about a cause-effect relationship between catatonia and NMS, but no consensus as yet. Malignant catatonia can be misdiagnosed as NMS, but lack of response to bromocriptine and dantrolene, and improvement with benzodiazepines differentiates it from NMS. Our case re-emphasizes the role of catatonia, dehydration and escalation of antipsychotic therapy, especially the depot forms, in development of NMS. Patients with psychosis are often poor feeders. Changes in their total body water content with fluctuating nutritional status significantly alter the volume of distribution of drugs and consequently, their pharmacokinetics. More caution and close monitoring is warranted in treating such patients.

P1-16
TARDIVE DYSKINESIA: MECHANISM, IDENTIFICATION, AND CURRENT TREATMENT IN THE SECOND GENERATION ANTIPSYCHOTIC ERA

Lead Author: Diana Kurlyandchik, B.Sc., M.D.

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ABSTRACT:
Tardive dyskinesia, a medication induced movement disorder characterized by the late onset of involuntary, repetitive body movements, was first described in the 1950s, coinciding with the introduction of the first antipsychotic medications to the market. The risk of tardive dyskinesia rises with increased age, longer duration and higher dose of medication treatment, and using first generation antipsychotic medications. Lifetime prevalence of TD among individuals using antipsychotic medications ranges widely, but is estimated to be approximately 15-25%, with a higher prevalence in the elderly. The risk per year for development of TD is approximately 5% for treatment with typical compared to 1% for treatment with second generation antipsychotics (SGA.) Despite the increasing usage of atypical antipsychotics in today's market, tardive dyskinesia remains a persistent and clinically relevant side effect of both first and second generation antipsychotic agents. It is often undiagnosed and the symptoms are inadequately addressed by providers, presumably, because patients are often not aware nor disturbed by the symptoms. In this poster, we review methods of diagnosis in addition to treatment options for TD. Further, we examine new research on the numerous substances that have been investigated to treat tardive dyskinesia; which include Vitamin E, benzodiazepines, melatonin and tetrabenazine. In reviewing this data, we aspire to improve awareness and management of tardive dyskinesia for the thousands of patients who may be distressed, embarrassed and even socially ostracized by these involuntary movements which have been iatrogenically induced.

P1-17
PSYCHIATRIC RESIDENT PERCEPTIONS OF FORENSIC PSYCHIATRY FELLOWSHIP

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ABSTRACT:
Today there are an alarming number of mentally ill patients engaged with the criminal justice system. Further, the legal aspects of medicine have become exceedingly important in contemporary medical practice. To address legal issues in Psychiatry, The American Academy of Psychiatry and the Law was formed in 1960. The American Board of Forensic Psychiatry was established in 1976, and formal examinations by the American Board of Psychiatry and Neurology began as recently as 1994. It was only in 1997, that the Accreditation Council for Graduate Medical Education (ACGME) began certifying training programs in forensic psychiatry. Training in Forensic Psychiatry is unique because trainees must learn to transition from the role of healer to objective evaluator on behalf of third parties, a task that differs from principles of general medical care and treatment. Currently, there are about 43 ACGME Accredited Forensic Psychiatry Fellowship programs, offering approximately 75 fellowship spots. Among the Accredited Psychiatry Fellowships, Forensic Psychiatry constitutes the smallest number of programs in the USA. Many general psychiatry residency programs offer electives in Forensic Psychiatry, but despite this, the level of awareness amongst trainees is variable due to several factors which may include a perceived level competitiveness and of sophistication of legal expertise, a difficult patient population, concerns for personal safety and a lack of continuity in patient care. In this poster, we explore awareness of Forensic Psychiatry curriculum and attitudes towards sub-specialty training in Forensic Psychiatry amongst New York City General Psychiatry Residency Trainees. We investigate their reactions and their main concerns about pursuing training in this sub-specialty with an aim to inform future policy decisions in the formulation of forensic psychiatry education. Assessing the level of enthusiasm amongst residents towards training in Forensic Psychiatry will allow modification of existing curricula aimed at the concerns of trainees, and encourage future expansion of the field.

P1-18
MANAGING NEUTROPENIA IN PATIENTS TREATED WITH CLOZAPINE

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ABSTRACT:
Introduction: Clozapine, a serotonin 2A/dopamine D2 antagonist, was the first antipsychotic to be recognized as atypical and having few extrapyramidal symptoms. Clozapine is associated with a 0.5%–2% risk of developing life-threatening agranulocytosis and a 2%–3% risk of developing neutropenia. Even though it was developed in 1961, it was not approved for use in the United States until 1990 due to reports of agranulocytosis in patients treated with clozapine in 1975.

Method: We discuss 2 patients taking clozapine who developed neutropenia that was managed so that the patients could be maintained on clozapine.

Discussion:Case1 had been taking lithium before he was given clozapine, and his counts initially were within normal limits. While on clozapine when lithium was stopped, he developed neutropenia. However, because he did not improve, he was rechallenged with clozapine along with lithium, and the counts improved considerably even with 300 mg bid dose of clozapine. It is well documented that lithium induces neutrophilia shortly after initiation of treatment , usually when the concentration of lithium in the blood is 0.4 to 1.1 mEq/l. Apart from redistributing granulocytes that are marginated or in the bone marrow reserve, lithium also stimulates granulocyte production/granulopoiesis, possibly by acting as a granulocyte-stimulating agent . Lithium has been used to prevent neutropenia in patients taking clozapine and to facilitate initiation of clozapine in the presence of preexisting neutropenia and in patients with benign ethnic neutropenia.

Case 2 had a history of schizophrenia that responded well to clozapine. Her neutropenia was precipitated by interferon, which was prescribed by her hepatologist. The use of filgrastim brought up her counts and allowed us to use clozapine. Both granulocyte colony-stimulating factor and granulocyte-macrophage colony-stimulating factor have been used in the treatment of clozapine-induced agranulocytosis . Whereas most cases of clozapine-induced agranulocytosis occur in the first 3 months of starting clozapine, it can occur later if the patient is given drugs that have a potential for suppressing the bone marrow. Other risk factors include increasing age, female gender, and HLA-B38 phenotype.

Conclusion: Despite the side effects, it is one of the most efficacious antipsychotics and is particularly effective in treatment-refractory patients. In patients whose illness responds to clozapine effective management of the side effects can permit these patients to continue taking clozapine and lead to a tremendous improvement in their quality of life

P1-19
COMPARISON OF TIME SPENT ON MANAGEMENT OF PSYCHIATRIC EMERGENCIES IN TERTIARY CARE HOSPITALS WITH RESIDENCY TRAINING PROGRAM'S TEACHING CURRICULUM

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ABSTRACT:
Introduction: Psychiatric emergency rooms are critical to both the mental health system and the social service networks of many communities and serve unique and significant functions within the mental healthcare system. There is felt to be a gap concerning the amount of time spent in work activities of staff in Psychiatric emergency rooms, their interaction and their perceptions of their work. The literature is relatively sparse, with little systematic research on either service provision or areas of clinical teaching to medical students and residents.

Objectives: To determine the most predominant causes of psychiatric presentations to the emergency room in tertiary care settings. To determine and compare the number of hours spent by residents and staff on managing different emergency psychiatric presentations. To study important topics that need to be incorporated into core academic teaching curriculum in psychiatry residency programs based on emergency psychiatric presentations.

Methods: Charts of all psychiatric emergency room patients from a five-year period, April 2006 to March 2011, were reviewed retrospectively. The collected data included patients' date and time of visits, number of hours spent by the residents and staff, gender, age and primary presenting diagnosis. Emergency room presentations were divided by ICD -10 criteria into 11 diagnostic clusters. Average time as well as total percentage of time spent by the staff and residents was studied in each cluster of diagnoses separately. Postgraduate university psychiatry residency teaching curriculum for the year 2010 and 2011 was studied and average time spent by residents in each cluster diagnoses topics was calculated. Time spent in emergency room managing different cluster of diagnoses was then compared with time spent in academic teaching by residents.

Results: One-way ANOVA analysis revealed a significant difference in management time between the cluster groups. After dividing the diagnoses into clusters, we compared the percentage of total time spent on each diagnostic cluster in the ER to the percentage of total time that is spent on each diagnostic cluster in the psychiatric curriculum. From this analysis we could observe that there were large differences in the proportion of time that is spent on each of these types of diagnoses in the ER as compared to the curriculum.

Conclusions: Out of all patients presenting to the ER for psychiatric reasons, the largest two groups were patients diagnosed with Substance Related Disorders and Anxiety Disorders. The time spent on each patient by staff and residents in the ER was significantly higher for a patient presenting with diagnosis Delirium and Dementia. When comparing this particular program's teaching curriculum, we found that a greater amount of total time is spent in the ER on anxiety and substance use disorders as compared to the total amount of time these topics were presented in the teaching curriculum.

P1-20
DEXTROMETHORPHAN-INDUCED PSYCHOSIS

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ABSTRACT:
Over-the-counter medications available without prescriptions are generally viewed safe for public consumption. However, when used in excess, these medications can lead to adverse consequences. There are multiple over-the- coun-

ter medications that have potential for abuse, and dextromethorphan is one such drug. We describe case series of Dextromethorphan abuse in different age groups which presented with severe psychiatric manifestations. These cases highlight the importance of carefully reviewing both prescribed and non-prescribed medications that are being used by patients, especially in the emergency care setting.

Case Reports: We reviewed three different cases presented with DXM abuse. In the first case, 46 y/o single white female was brought by police after she allegedly stabbed her demented 78 y/o aunt repeatedly in the head and then cut her wrist in the attempt to kill herself. She was very agitated, paranoid and endorsed command-type auditory hallucinations. Pt reported self-medicating at home to treat the withdrawal symptoms from oxycodone with DXM cough syrup. In the remaining two cases, 19 y/o white males were brought into the hospital for psychiatric evaluation after abusing DXM and became very violent, aggressive and paranoid.

Discussion: Dextromethorphan overdose results in neurobehavioral effects similar to ketamine and phencyclidine which causes severe agitation, hallucinations "out of body" sensations and dissociation. DXM is generally not detected in routine urine drug screen tests and there have been reports of false positive results for phencyclidine on tests done by liquid chromatography. Abuse of DXM is more commonly seen in young population (12-25 yrs.); only a limited number of cases are reported among middle age population. In the above discussed cases, Patients are presented with psychosis after abusing DXM. There are several factors that could have led to this choice of abuse such as its easy availability, its abuse potential, its similar or limited dissociative anesthetic like euphoric effects and opioid like actions and misleading information available on the internet about its abuse.

Conclusion: Dextromethorphan is an easily accessible and potentially-abused over the counter cough medication which is life threatening when taken in excessive amounts. Hence, it is a worthwhile endeavor for authorities to closely monitor products containing dextromethorphan (similar to pseudoephedrine), and to keep these products behind the counter under the observation of a pharmacist. Also, it is vital for health care providers to perform detailed assessment of all the over- the-counter medications used by patients and their drug-drug interactions.

P1-21
PERSPECTIVES ON PHARMACOTHERAPY FOR ALCOHOL USE DISORDERS

Lead Author: Caridad Ponce Martinez, M.D.

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ABSTRACT:

Introduction: The NIAAA has recommended that medications be considered in treating patients with alcohol dependence, but prior studies have shown that this practice remains uncommon. This study was designed to assess physicians' perspectives on the use of pharmacotherapy in the treatment of Alcohol Use Disorders (AUD), in an effort to identify strategies that would lead to greater prescription of medications as an adjunct in treatment.

Design: An anonymous online survey was designed, collecting information about physicians' use of medications in treatment of AUDs, obstacles in prescribing and factors that would lead to increased pharmacotherapy. Medications evaluated included 3 FDA-approved and several off-label. Physicians were reached via email, by contacting state chapters of the American Academy of Family Physicians and the American Psychiatric Association, as well as all ACGME-accredited Psychiatry and Family Medicine residency programs in the US. No compensation was offered for survey completion.

Results: As of 5/13/13, 396 surveys were completed. 45.5% of participants were Psychiatrists vs. 52.8% Family Medicine (FM) physicians; 6.6% were Addiction specialists. 62.1% of participants worked at a teaching hospital and nearly half of all physicians completed residency >10 years ago.

73.5% of all respondents have used medications to treat AUDs. Of these, psychiatrists were more likely to have used naltrexone, versus disulfiram by FM physicians. Psychiatrists had the best results with naltrexone. Both specialties identified concerns about efficacy with all non-FDA approved medications. Lack of patient compliance was the primary deterrent for greater use of disulfiram. For psychiatrists, cost and efficacy concerns were the major barriers against greater use of naltrexone and acamprosate, respectively, while FM physicians had little experience with both of these. 80% of all surveyed who had not prescribed medications identified lack of training/experience as a reason and 80% of all respondents would employ more pharmacotherapy if they had increased training. Having more time with patients was also a factor that would incentivize FM physicians to use more pharmacotherapy. The most popular form of desired training was continuing medical education at their workplace.

Conclusion: Most psychiatrists and family physicians sampled have used medications to treat AUDs, but identify lack of training as the main problem impeding greater prescription. There were efficacy concerns regarding all non-FDA approved medications. Efforts towards determining the best predictors for treatment response amongst patients should help alleviate some of the uncertainties reported with medications' efficacy and would lead to a more individualized approach to treatment. Our survey also highlights a unique opportunity for intervention – incorporating education in residency training programs about use of pharmacotherapy as part of the treatment of AUDs.

P1-22
"PROCEED WITH CAUTION": PSYCHOSIS RELATED TO ZONISAMIDE THERAPY

Lead Author: Anupama Ramalingam, M.D.

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ABSTRACT:

Zonisamide is an anticonvulsant medication that is primarily used for adjunctive treatment of partial seizures. It has been used in Japan and Korea for over 20 years. Several Japanese-language case studies report psychosis and/or mania with zonisamide. Psychosis incidence in one study ranged from 1.9% to 2.3% of patients treated with zonisamide which is concordant with 2% incidence of schizophrenic behavior reported by the manufacturer. However, it should be noted that these adverse effects have usually appeared during polypharmacy, rarely during monotherapy with zonisamide. It remains unclear, therefore, as to whether these adverse effects during polytherapy were actually due to zonisamide, because of inter ictal psychosis and the fact that other anticonvulsant medications also engender mental side effects. We present a case report of a 29 year old male who was started on zonisamide for adjunctive treatment of seizures and admitted to psychiatric service with psychotic symptoms. Patient is a 29 year old African American male with a history of complex partial seizures refractory to different anticonvulsant medication and no significant past psychiatric history. He was started on Zonisamide, after having a poor response to divalproex. After few months, he presented to psychiatric service for psychosis. It was reported that within 5 months of starting zonisamide the patient had paranoia, delusions of reference and persecutions, thought broadcasting and tangential thought process. His family confirmed that there was a definite change in his behavior after zonisamide initiation and progressively worsened to the point that it affected his daily activities. There was also a strong family history of paranoid schizophrenia and seizure disorder in the family. He was admitted to psychiatric service and a neurology consultation was done. Zonisamide was stopped and he was started on other anticonvulsant and antipsychotic medication. He tolerated the medication changes well and his psychotic symptoms gradually improved.

Discussion: It is well established that Zonisamide can induce psychosis within weeks of initiation of therapy. The mechanism for this adverse event is not clear. It is postulated that it increases the extracellular and intraneuronal levels of dopamine in the striatum and hippocampus in rat thus leading to psychosis. Our patient had multiple risk factors for development of psychosis including family history of schizophrenia, use of zonisamide and phenytoin and the presence of seizures. The latter 3 factors were described in a study as possible risk factors for development of psychosis. Also the resolution of symptoms in a short period of time suggests that it was an adverse event from the medication. Considering detrimental impact of psychosis on the quality of life, the knowledge about risk factors is highly crucial. It is important to use caution in starting zonisamide for patients with family history of schizophrenia or other psychosis.

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P1-23
SOMATIC COMPLAINTS AND CONCERNS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Lead Author: Chandresh Shah, M.D.

ABSTRACT:

Patients seeking help for depression were given Beck Depression Inventory (BDI) to complete in an outpatient mental health clinic over a period of 6 months. Among them 37 patients were diagnosed with Major Depressive Disorder (MDD). There were 22 male (age=56.41+/-13.78 years) and 15 female (age=51.07+/-12.31 years) patients. These patients obtained a total BDI score of 28.41+/-9.61 and a severity score of 2.83+/-0.83, placing them in a category of having moderate MDD. As expected, the most common complaint was of "sad mood" expressed by all (100%) patients and scored highest at 2.59+/-0.49 (P<0.005). It was interesting as well as surprising to find that the next 4 most commonly expressed complaints and/or concerns by more than 90% of patients were related to somatic issues. The score for "change in sleep pattern" was 2.08+/-0.86 (P<0.001), that of "fatigue" was 2.08+/-0.68(P<0.001), that for "loss of energy" was 1.73+/-0.77(P<0.05) and that of "change in appetite" was 1.70+/-0.87(P<0.05). Contrary to common perception score for "suicidal thoughts or wishes" was very low at 0.64+/-0.75 (P=NS) reported by less than 30% of patients.

These data show that somatic complaints and/or concerns are highly prevalent in patients suffering from MDD. This may also suggest significance of screening for depression in primary care.

P1-24
AN ANTIPSYCHOTIC DRUG TAPERING PROTOCOL: 2-YEAR OUTCOMES

Lead Author: Sandra Steingard, M.D.

Co-Author(s): Melissa Randall, M.D.; George Vana

ABSTRACT:
Psychotic symptoms are typically treated with antipsychotic medications. When the drugs are discontinued abruptly many, but not all, patients become ill again. Standard practice is to continue these drugs indefinitely. The medications, however, are associated with a number of long-term serious side effects such as neurological impairment, diabetes, and obesity. In addition, many patients may be started on doses that are higher than is required to prevent relapse and some data suggest that patients who are not maintained on these medications long-term may have better outcomes. It is, therefore, important to try to determine the lowest dose required for maintenance of remission. We lack guidelines for determination of minimal effective doses. This is a chart review from two practices in which patients who were stable on antipsychotic medications were informed of long-term risks and offered the choice of gradual dose tapering to seek the minimal effective dose of antipsychotic drug. Doses were generally reduced at a rate no greater than 25% of initial doses at 3 - 6 month intervals.

We present data from over 90 patients who have been followed for two years, including patients who chose to taper medications, those who abruptly discontinued medications, and those elected to continue on the same dose of medications. We report on rate of hospitalization as well as other adverse effects in each group. We also report on employment status in each group.

P1-25
A CASE OF TREATMENT-RESISTANT SCHIZOAFFECTIVE DISORDER WITH DRAMATIC RESPONSE TO ASENAPINE AUGMENTATION

Lead Author: Mark Bryan Ting, M.D.

Co-Author(s): Krishna Bezwada, M.D.; Subramoniam Madhusoodanan, M.D.

ABSTRACT:
Objective: We are reporting the case of a patient with treatment-resistant schizoaffective disorder who responded dramatically to augmentation with asenapine.

Methods: Data obtained from chart review. Clinical Global Impression (CGI) scores were performed at baseline, weekly, and at endpoint.

Results: Patient showed dramatic clinical improvement upon augmentation of olanzapine with asenapine. Baseline CGI Severity was 6 while endpoint CGI Severity and Improvement scores were 3 and 1 respectively.

Conclusion: Although we are not advocating the use of multiple antipsychotics, there are situations where augmentation with another antipsychotic may be beneficial. Improvement may be due to synergistic receptor affinities. Patients not responding to certain antipsychotics can still improve on others. Further controlled studies of asenapine augmentation in this population are recommended.

NO. 26

KAVA CASE SERIES: SERIOUS SIDE EFFECTS WITH PSYCHOTROPICS RELATED TO POSSIBLE INHIBITION OF CYTOCHROME P450 ENZYMES DUE TO CONCURRENT KAVA USE

Lead Author: Tara Pundiak Toohey, M.D.

Co-Author(s): Brett Y. Lu, M.D., Ph.D.; Cherisse Wada

ABSTRACT:
Introduction: Kava is a herbal remedy with sedative effects popular amongst Native Pacific Islanders for centuries who use it for its sedative effects and in religious ceremonies. Kava has also gained popularity in Western countries due to its anxiolytic properties. Very little is known about potential adverse reactions to Kava other than a few reports of hepatotoxicity. However, there is growing evidence that Kava can strongly inhibit cytochrome P450 (CYP) enzymes and thus poses a potential pharmacokinetic interaction with various medications, including psychotropics. Whether such potential interaction between kava and standard medications leads to dangerous clinical outcome has not been well-studied.

Case description: We present two cases of patients seen on the psychiatric emergency and consult service who developed severe side effects from psychotropic medications in the context of kava use. The first case involves an agitated patient with bipolar disorder who developed respiratory depression and metabolic encephalopathy after standard doses of haloperidol and lorazepam. The second case is of a patient with restless leg syndrome that progressed to a dopamine dysregulation-like syndrome after given low dose of dopaminergic medication. In both cases kava use may have affected the metabolism of the psychotropic medications, leading to serious side effects .

Discussion: Growing research indicates that kava likely alters concentrations of co-administered psychotropics in general. There remains no formal recommendations for safe use of psychotropics with kava, as there are no known systematic studies that investigate the pharmacokinetic interactions between kava and specific psychotropics. There needs to be greater awareness of safety issues among recreational and religious kava users who use prescription medications with dose-related serious side effects. Individuals with low intrinsic CYP enzyme activities may be at high risk for dangerous drug-drug interactions when using kava. Thus kava-users could benefit from pharmacogenomic testing to determine baseline ability to metabolize medications and their susceptibility to any potential kava inhibition of CYP. This information along with further research about kava and its metabolites could help determine a pharmacologic solution for patients who require psychotropic medications but would like to preserve cultural traditions and religious practices.

P1-27
CONDUCTIVE HEARING LOSS: A RARE LONG-TERM SIDE EFFECT OF CLOZAPINE USE

Lead Author: Jamsheed H Khan, M.D.

Co-Author(s): Frank Senatore

ABSTRACT:
This patient is a 55 year old Caucasian female, single, never married, with a past psychiatric history of schizophrenia, paranoid type, continuous for 35 years. The patient reported persecutory delusions that her sister and mother were trying to hurt her, control her, and restrict her from traveling anywhere outside the house. She also reported delusions of being a famous writer. The patient reported a previous psychiatric history of 3 inpatient psychiatric hospitalizations due to bizarre behavior and agitation. She had a history of compliance to follow-up with a psychiatrist every 3 months, as well as to her psychopharmacological treatment. She reported decreased sleep, but did not have a history of self-mutilating behavior, suicide attempts, or assaultive behavior. She had no known history of alcohol or substance use. On exam the patient appeared age appropriate but was disheveled. Her speech was notably loud, and her thought associations were circumstantial and psychotic. She had minimal insight into her disease and treatment, and judgment was poor. Her mood was demonstrably euthymic and affect was constricted. She reportedly denied suicidal or homicidal ideations at the time of the interview. The remainder of the mini-mental status exam was normal. The patient was taking risperidone, quetiapine, and paroxetine, in addition to the medications losartan, hydochlorothiazide, and simvastatin for her general medical conditions. Incidentally, while reviewing the patient's past psychiatric history and treatment, it was noted that she was taking clozapine for more than a decade up until 1995.

Discussion: Presently, to our knowledge there have been no studies on an association between long term clozapine use and the development of conductive hearing impairment. In addition, there are few studies or case reports on the long term effects of clozapine use, likely because of the high incidence of agranulocytosis and seizures associated with this drug that mandate discontinuation. In the 1970's when clozapine was first introduced in Europe, its eminent side effects were distinguished in a relatively short period of time, prompting its withdrawal within 4 years of being approved. However, multiple studies over the following decade demonstrated its superior effectiveness compared to other typical antipsychotic drugs. Although it was eventually FDA approved in 1989 for treatment resistant schizophrenia, its endorsement came with several black box warnings for agranulocytosis, seizures, myocarditis, cardiac and respiratory side effects. From this initial approval through present day, little, if any information has been elucidated on clozapine's relationship to hearing impairment. This case presents a particularly unique patient reaction to clozapine that should not be overlooked in patients on long term treatment, because conductive deafness is so devastating to a patient.

P1-28
IS THERE AN ASSOCIATION BETWEEN POLYCYSTIC OVARIAN SYNDROME (PCOS) AND BIPOLAR DISORDER?

Lead Author: Jamsheed H Khan, M.D.

Co-Author(s): Dr.Ulfat Shahzadi; Dr. Mehdi

ABSTRACT:
Polycystic ovarian syndrome and bipolar disorder are complex, poly-genetic disorders that share common endophenotypes in insulin resistance, hyperlipidemia, and other metabolic abnormalities. Clinically, it is also important to recognize that PCOS patients are prone to bipolar disorder, and that the treatment of one disorder may in fact help ameliorate the effects of the other.In addition to the adverse psychosocial, vocational, and societal impacts of bipolar disorder, the lifetime suicide rate associated with bipolar disorder (15.6%) is higher than corresponding rates in any other psychiatric disorder. Polycystic ovarian syndrome is a serious endocrine disorder and a leading cause of female infertility. PCOS affects approximately 4–11% of reproductive-aged women and is associated with hyperandrogenism; insulin resistance, ovulatory and menstrual abnormalities (2).PCOS is associated with no of psychiatric co-morbidities, and has increased risk for bipolar disorder, generalized anxiety disorder, borderline personality disorder and schizophrenia.

Case History: Miss SL is 30 year old woman with h/o bipolar disorder, borderline personality disorder and polycystic ovarian disease, presented in ER after she was agitated, labile and made a suicidal statement. She had more than twelve in-patient psychiatric hospitalization and non-compliant with medicine and follow-up. Remarkable for extensive history of mood lability, violence, aggression, made serious suicidal attempts by cutting herself in the past and now jumped in front of oncoming traffic. Patient needed many times four point restraints in her hospitalization course. On examination white woman thinner than her usual appearance, speech markedly loud and pressured, flight of ideas, tangential and circumstantial, judgment and insight impaired and mood angry.

Discussion: In a study of ambulatory treatment for PCOS, authors found that mood disorder represented 78% and major depression 26.4% of the identified mental disorders in the whole sample of study(1).The results also showed a greater prevalence than expected(11.1%) for bipolar disorder types I and II..A close relationship between BD and PCOS was observed by Rasgon et al suggesting that a greater incidence of menstrual alterations and PCOS among patients with BD is part of the hormonal abnormalities intrinsic to BD and not just a result of the therapeutic treatment (e.g., valproic acid) used for this disorder(2).

Conclusion: PCOS may inherently arise in a substantial minority of women with possible bipolar disorder potentially via a shared hypothalamic-pituitary-gonadal axis defect. Because bipolar illness has previously been linked with thyroid and adrenocortical endocrinopathies (8), it is conceivable that hypothalamic-pituitary axis dysfunction could demarcate a biologically distinct bipolar subtype. More research needs to be done to establish a link between bipolar disorder and PCOS and develop effective treatment modalities.

P1-29
INCIDENCE OF TARDIVE DYSKINESIA: A COMPARISON OF LONG-ACTING INJECTABLE AND ORAL PALIPERIDONE

Lead Author: David Hough, M.D., M.H.S.

Co-Author(s): Xu, Haiyan, PhD; Bossie, Cynthia PhD; Buron Vidal, José Antonio, M.D.; Fu, Dong Jing, M.D., PhD; Savitz, Adam, M.D.; Nuamah, Isaac, PhD; Hough, David, M.D.

ABSTRACT:
Objective: To estimate the incidence of tardive dyskinesia (TD) in long-term studies of once-monthly injectable paliperidone palmitate (PP) and oral paliperidone (Pali ER) using Schooler-Kane criteria and spontaneously reported adverse events (AE).

Methods: Patient level data were pooled from completed schizophrenia and bipolar studies (four PP [N=1689] and six Pali ER [N=2668]) of ?6 months duration that included Abnormal Involuntary Movement Scale (AIMS) assessments. Cases of TD based upon Schooler-Kane criteria defined for probable TD and persistent TD were determined using AIMS total score (items 1-7). Patients scoring ?2 on two or more items or ?3 on at least one item were considered to have qualifying scores for either probable or persistent TD. Probable TD cases included patients with qualifying AIMS scores for ?3 months, and persistent TD cases included those patients with qualifying AIMS score persisting for an additional 3 months (?6 months total). Subjects were exposed to study medications through the entire assessment period. Adverse event reports of TD were summarized. TD incidence was calculated in treatment-emergent cases only. Impact of duration was assessed by summarizing the monthly incidence rate of dyskinesias with AIMS total score ?3.

Results: In schizophrenia studies, TD incidence was reported for PP (N=1689) vs. Pali ER (N=2054), respectively as: AE, 0.18% vs. 0.10%; probable, 0.01% vs. 0.19%; and persistent, 0.01% vs. 0.05%. In bipolar studies (Pali ER only [N=614]), TD incidence was zero (for spontaneous AE reporting, probable and persistent TD). Incidence of dyskinesias (total AIMS score ?3) was highest within the first month of treatment with both formulations (PP: 13.1%; Pali ER: 11.7%) and steadily decreased over time (for months 6-7: PP: 5.4%; Pali ER: 6.4%).

Conclusions: In this post-hoc analysis, risk of TD and incidence of dyskinesias was similar between PP and Pali ER treatments. Long-Term TD risk appeared to be similar regardless of route of administration. Longer cumulative exposure did not appear to increase dyskinesia risk.

POSTER SESSION 2

P2-01
STOP AND DON'T SMELL THE SHOE POLISH: THE USE OF INHALANTS AMONG ADOLESCENTS

Lead Author: Kola Aloa, M.D.

Co-Author(s): Andrey Moyko; A. Alao

ABSTRACT:
Introduction: Inhalant abuse among U.S. adolescents is a common occurrence. Unlike the illegal drugs, inhalants are readily available in an average household in many forms. According to the National Inhalant Prevention Coalition, between 100-125 deaths are attributed to inhalant abuse annually. We will describe a case of a Kenyan immigrant who developed acute psychotic episode following inhalation.

Case Report: A 17 year old Kenyan immigrant was brought to the ED after inhaling shoe polish. She has a history of PTSD from being raped while on the street in Kenya. She was later adopted and brought to the USA. Her psychotic symptoms resolved after she was treated with olanzapine 5mg.

Discussion: Medical complications include, but are not limited to the following: central nervous system, cardiovascular, pulmonary, gastrointestinal, renal, hematologic, and dermatological. In addition, to medical complications, there are psychiatric complications as well. Adolescents abusing inhalants may often present with hallucinations, emotional disturbances, inappropriate affect, manic symptoms, or suicidal ideation. Inhalant use has also been associated with conduct disorder in adolescents, as well as major depressive disorder and substance abuse disorder later in life,

Conclusion: The use of inhalants to achieve a "high" continues to be a dangerous occurrence within the adolescent population. The consequences of inhalant abuse go beyond the immediate medical complications or social effects. An adolescent's mental health may be severely impaired, with psychiatric effects extending well into adulthood. Physicians and parents should be aware of the possibility of psychosis caused by inhalant abuse.

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P2-02
VALIDATION OF A MEASURE OF ALLIANCE FOR AN ADOLESCENT INPATIENT SETTING

Lead Author: Ronke Latifatu Babalola, M.D., M.P.H.

ABSTRACT:
The link between alliance and treatment outcome is robust. Yet, few, if any, measures exist to assess alliance with hospitalized adolescents. The present study looks to investigate a brief self-report measure of inpatient treatment alliance to be used with adolescents. The scale is designed incorporating items that tap the 3 factors of alliance (bond, goals and collaboration) to assess the alliance the patient has with his or her treatment team. Our results show that the Inpatient-Treatment Alliance Scale (I-TAS, Blais, 2004) is unifactoral, shows good psychometrics and is linked in theoretically meaningful ways to measures of object-relations, psychological functioning, outcome and engagement in individual psychotherapy.

P2-03
EVALUATING HEALTH INSURANCE COVERAGE, MEDICAL RESOURCE USE, AND RECIDIVISM IN PERSONS WITH SCHIZOPHRENIA

Lead Author: Carmela Benson, M.S.

Co-Author(s): Lian Mao; John Fastenau; Larry Alphs; Lynn Starr

ABSTRACT:
Background: Persons with schizophrenia have higher risks of arrest and incarceration and are less likely to have health insurance coverage (HIC) compared with the general population. Research has found that having health insurance coverage after release from jail may be associated with lower rates of rearrest and drug use. We describe 2 cohorts of subjects based on their HIC enrolled in PRIDE (Paliperidone Research in Demonstrating Effectiveness), an ongoing, pragmatic, 15-month, randomized, active-controlled, open-label study of paliperidone palmitate, compared with oral antipsychotic treatment in adults with schizophrenia who recently were released from incarceration. We hypothesized patients without HIC would have lower resource use and would be more likely to experience recidivism compared with patients with HIC.

Methods: Subjects randomized as of 15March2012 were included in this interim analysis. Subjects with commercial or public health insurance formed the "with coverage" cohort (WC) and those without HIC formed the "no coverage" cohort (NC). At baseline, resource utilization in the past 12 months before the last incarceration was assessed using the resource use questionnaire (RUQ). RUQ collects sociodemographic information, outpatient/inpatient services, emergency room (ER) visits, emergency medical services (EMS), and contacts with the criminal justice system. Demographic and clinical characteristics, reasons for arrest/incarceration, and resource utilization at baseline were compared between the 2 cohorts. The odds of hospitalization, visits to the ER, use of EMS, and recidivism (defined as 3 or more arrests/incarcerations) were estimated for the 2 cohorts and were compared using the Mantel-Haenszel test. No adjustment was made for multiplicity.

Results: Of 340 subjects analyzed, 39.1% (n=133) had no insurance coverage. The 2 cohorts were comparable in demographics and clinical characteristics. Reasons for and frequency of arrests differed between the 2 cohorts, with probation/parole violation highest in the NC cohort (24.8% vs 13.7%, p=0.009). Mean visits to any type of outpatient health professional such as a psychiatrist (NC=4.7, WC=5.6) or mental health facility such as a community

mental health center (CMHC) (NC=6.6, WC=5.4) were low in both cohorts. During the past 12 months, the odds ratios (p-values) for hospitalization, visits to ER, EMS, and recidivism in the NC versus the WC cohort were 0.60 (p=0.071), 0.73 (p=0.191), 0.74 (p=0.267), and 1.47 (p=0.287), respectively.

Conclusions: This interim analysis showed lower healthcare use but higher recidivism among schizophrenia patients without versus with health insurance coverage. Further studies and analysis are warranted to understand the impact of health insurance coverage on patient outcomes.

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P2-04
THE JOURNEY FROM PAPER TO ELECTRONIC MEDICAL RECORDS: A RESIDENT-DRIVEN HEALTH SERVICES INITIATIVE

Lead Author: Maria Mirabela Bodic, M.D.

Co-Author(s): Abraham Taub DO; Jimmy Wu; Connie Grande RN; Corey Weiner M.D.; Theresa Jacob PhD, MPH

ABSTRACT:
Background: Maimonides Medical Center is well known in New York for its busy Emergency Medicine Department (ED) with close to 120,000 evaluations in 2012. The Psychiatric Emergency Room was opened in October 2009 due to a growing need for a dedicated space to serve the mental health population. The process of integrating the Psychiatric Emergency Room within the overall ED was of utmost importance in order to provide high quality patient care. After the Psychiatric Emergency Room opened, it became obvious that paper documentation created difficulties in communication, was time consuming and overall impeding patient flow. The need for transition from paper to Electronic Medical Record (EMR) was quite apparent. In academic medical centers, residents are at the forefront of implementing new and innovative systems for efficient patient care as evidenced by this resident-driven project.

Objectives: To integrate the documentation in the Psychiatric Emergency Room within the EMR of the ED.

Methods: A task force consisting of physicians, nurses and information technologists was created in the summer of 2011 that met on a regular basis. In phase 1, the transition from hand written documentation to computerized Microsoft Word based templates was initiated. This phase consisted of: designing templates, feedback from team members and implementation once requisite approval was obtained. The goal in phase 2 was the conversion of these Word templates to psychiatry-specific prototypes embedded in the EMR. In this phase, the work revolved around identifying the needs for proper psychiatric documentation and adapting to the existing technical capabilities of the EMR. Testing, training and staff education were employed to assure smooth transition to the EMR.

Results: The project was successfully completed in 1.5 years. Although there were multiple obstacles during the process, mostly related to systems issues and the notion of change in a health care organization, they were overcome through improved communication and education. The introduction of computerized documentation has significantly enhanced the functioning of the Psychiatric Emergency Room. Positive feedback has been received from collaborating departments including Internal Medicine, Pediatrics and Surgery, regarding the increased accessibility and availability of psychiatric documentation.

Conclusions: There is increased value in selecting residents to design and implement projects of which they will ultimately be the most frequent users. This project created opportunities for the professional development of residents and lead to a greater involvement in quality improvement projects overall. Patient care improved significantly through comprehensive, legible and more efficient documentation. Interdepartmental relations benefited as well from the increased interaction and collaboration. Patient outcomes and cost-effectiveness have not been analyzed, but would be a future direction of this initiative.

P2-05
DIAGNOSIS ACCURACY BASED ON DSM CRITERIA AS DOCUMENTED BY PSYCHIATRY RESIDENTS

Lead Author: Maria Mirabela Bodic, M.D.

Co-Author(s): Scot McAfee, M.D.; Theresa Jacob, PhD, MPH

ABSTRACT:
Background: The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides a common language and standard criteria for diagnosing mental disorders. It is of paramount importance that all clinicians and investigators consider the same criteria and use a common language when deliberating DSM diagnoses. Despite the risks of inaccurate or incomplete diagnoses, very little has been written about complete chronicling of pertinent positive and/or negative criteria when diagnosing a mental disorder. We hypothesize that there is incomplete documentation of DSM IV TR criteria in the psychiatric evaluations to justify the Axis I diagnosis given to patients.

Aims: 1) To determine the accuracy of diagnosing Major Depressive Disorder (MDD) and Schizophrenia by DSM criteria; 2) To compare the level of accuracy between different settings, times and levels of training; 3) To identify the shortcomings of our documentation and develop an educational tool for teaching proper psychiatric documentation.

Methods: This study is a retrospective chart review of psychiatric evaluations performed at Maimonides Medical Center Emergency Room (ER) and Adult Outpatient Services (AOS) from 09/01/2011 to 06/30/2012. All evaluations were screened using software developed specifically for this project, collecting data on diagnosis, DSM criteria, time and setting of evaluations, level of training of the evaluating resident and patient demographics. The software adapts to the electronic medical records era and provides easy verification modalities for both residents and faculty aspiring to improve their documentation skills. The interface is user-friendly and permits fast, accurate data collection by using drop down menus and radio buttons. Accurate diagnosis was considered when all inclusion and exclusion criteria required in DSM were documented in the chart.

Results: MDD was diagnosed in 164 evaluations and Schizophrenia in 208. The overall level of accuracy was 43.8% (p<0.000), with no statistically significant difference between diagnoses (42.7% for MDD and 44.7% for Schizophrenia). The accuracy was lower in AOS (36.5%) than in ER (45.4%), with no significant difference between times of evaluation. Level of training was inversely correlated with the level of accuracy for MDD (PGY1s scored 52.4% compared to PGY4s 28.6%, p<0.044).

Conclusion: Although failure to probe for and record criteria for all DSM-specified diagnoses could result in over-, under-, or misdiagnosis of mental health disorders, to the best of our knowledge, this is the first study to examine the accuracy of Axis I DSM diagnoses based on the criteria documented by psychiatry residents in the medical record. The level of accuracy is low for both diagnoses, in both settings, at all times and at all PGY levels. Didactics, supervision and case-by-case teaching are needed with emphasis on how to use and how to document DSM diagnostic criteria, especially given the changes in DSM V.

P2-06
CHILDHOOD TRAUMA AND THE RISK OF SUICIDE: ANALYSIS OF THE CTQ IN SUICIDAL PSYCHIATRIC INPATIENTS

Lead Author: Jennifer Katherine Boland

Co-Author(s): Zimri Yaseen, M.D.; Irina Kogan, M.D.; Irina Kopeykina, B.A.; Fumitaka Hayashi, M.D., PhD; Anna Kreiter, B.A.; Igor Galynker, M.D., PhD

ABSTRACT:
Objective: Current research demonstrates an imperative need for identifying factors that contribute to suicide risk in psychiatric patients. Childhood trauma has been associated with a wide range of psychiatric disorders and is known to be a chronic risk factor for suicide in adulthood. As such, childhood trauma is important to consider when defining risk factors that lead to an imminent suicide attempt. At present, it remains unclear to what extent childhood trauma contributes to and has a "dose-response" relationship with acute suicide risk. We aim to investigate the relationship between childhood trauma and imminent suicide attempts in psychiatric inpatients using the Childhood Trauma Questionnaire (CTQ).

Methods: The 25-item CTQ was administered to 174 adult psychiatric inpatients who were admitted to Beth Israel Medical Center and St. Luke's Roosevelt Hospital Center with either suicidal ideation or a suicide attempt. This scale was administered during a semi-structured interview that collected demographic and clinical information along with data from psychometric scales such as the Beck Depression Inventory (BDI). Multiple statistical methods were used to evaluate the relationships among the data collected from the CTQ and these other scales.

Results: There were no significant results when the CTQ subscale scores (Emotional Abuse, Physical Abuse, Sexual Abuse, Emotional Neglect, and Physical Neglect) were compared between patients admitted to the hospital with suicidal ideation and those admitted with an attempt. Likewise there was no statistical difference in CTQ subscale scores between patients who attempted suicide after two months of being discharged and those who did not. There were, however, significant positive correlations between the severity of suicidal ideation and the CTQ Emotional Abuse subscale score; r=0.244, p=0.003, and between severity of suicidal ideation and CTQ Physical Abuse subscale score; r=0.233, p =0.005. The Emotional Abuse subscale score also showed a significant positive correlation with the BDI total score; r=0.221, p=0.008, as well as with all other CTQ subscale scores.

Conclusion: Higher scores on the Emotional and Physical Abuse CTQ subscales associate with both increasing measures of depression and increasing severity of patients' suicidal ideation. Our results suggest that retrospectively assessed childhood emotional and physical abuse correlates with severity of depressive symptoms but does not differentiate between those with suicidal ideation and those who are at risk for an imminent suicide attempt.

P2-07
IS INSOMNIA THE DESTINY TO DEPRESSION OR A CO-TRAVELER?

Lead Author: Shanel Chandra, M.D.

Co-Author(s): Rashi Aggarwal MD

ABSTRACT:

It has always been challenging to establish a link between depression and sleep disorders. Insomnia is a not only considered one of the symptoms in depression, but they share common neurobiology between them. Numbers of studies have shown that sleep disturbances act as a prodromal symptom of depression. Furthermore, 90% of the patients with Major Depressive Disorder have profound sleep disturbance in the form of frequent night time awakenings, trouble falling sleep and trouble maintaining sleep. Studies have also demonstrated that sleep in major depression is characterized by a longer periods of rapid eye movement (REM) sleep including a shortening of REM latency (i.e. the time between sleep onset and the occurrence of the ?rst REM period). Exposure to cholinergic stimulants reduces REM latency, particularly in major depressive disorder. In fact, it has been shown that healthy individuals at high risk for developing depression have greater sensitivity to cholinergic stimulation than those not at high risk. It is seen that patients with persistent insomnia not only have high chances to develop Major Depressive Disorder if untreated but also have higher chances of relapse in future if insomnia is not treated properly. Although, it is yet to be established that treatment of insomnia can help prevent the onset of depression, more studies would be further needed to establish if insomnia and depression share a common underlying cause or if insomnia should be considered a precursor to depression.

P2-08
PERVASIVE REFUSAL SYNDROME: A STORY UNTOLD

Lead Author: Shanel Chandra, M.D.

Co-Author(s): Mariam Bekhit, MD

ABSTRACT:
Pervasive Refusal syndrome is an interesting psychiatric disorder yet to be described in DSM. It is a syndrome involving predominantly teenagers in which patient refuses to eat, drink, walk, engage, showing active resistance to every help offered, thus making “resistance” ,the most important component of this condition. Etiology is complex and involves hopelessness and learned helplessness, thus affecting every domain of life leading to endangered state. Most of the times it is under-diagnosed as it has overlapping symptoms with major depressive disorder and catatonia. Treatment is not well defined but requires inpatient psychiatric hospitalization with involvement of mutimodal, multidisciplinary teams including pediatricians, nutritionists, psychotherapists and physiotherapists. We present a case of a 16 year old African American girl who had been unfortunate to experience the divorce of her parents with her father not being regular in visiting her. At presentation, the patient was struggling with depression, poorly responding to treatment for the past 3 yrs and had had 5-6 admissions in the past 2 yrs itself. She was admitted to child and adolescent floor, after being found severely depressed, catatonic, resistant and lying in a cardboard like sheet in bed, most of the times in fetal position. She was put on venlafaxine, lorazepam, olanzapine and mirtazapine for symptomatic management. Patient’s main cause of frustration and anger was her father not visiting her. Patient slowly showed some improvement and was discharged to partial hospital program, but became noncompliant with the appointment and treatment very soon. Patient decompensated again and ended up in the hospital with similar presentation. Multiple disciplinary teams were involved, including nutritionist, pediatrician, psychotherapists, physiotherapists. Both 1:1 and group therapists were involved. Patient’s voice became so soft, that team had to communicate to her by writing letters and that too patient being in fetal position. With continued pharmacotherapy and psychotherapy, patient was discharged again to a long term treatment plan. She had to be readmitted for similar symptoms and this time started forcing team to discharge her and scratching her face in frustration for which she had to be put under physical restrains multiple time. Intensive treatment and psychotherapy was continued with consistent encouragement from the team. Till date, patient is in an inpatient unit and is slowly and gradually improving. She continues to eat, drink, bath, going to groups under direct care of multiple teams. Our case shows, a patient in her teens, with classic symptoms of PRS, who after being exposed to intense stressors was not able to cope with it, and developed learned helplessness. In the same lines, till date PRS has been helpless to find a description in DSM IV or ICD-10. We think that it should be considered under MDD severe and recurrent or Oppositional defiant disorder.

P2-09
CONVERSION DISORDER WITH EXPRESSIVE APHASIA DIAGNOSED BY AMOBARBITAL INTERVIEW: A CASE REPORT

Lead Author: Richard Chung, M.D.

ABSTRACT:
The amobarbital interview has been a diagnostic and therapeutic tool in Psychiatry since 1929. There has been a general consensus in recent literature that its popularity has declined. Some postulate that safer medications such as benzodiazepines are more convenient and easier to use. Few Psychiatry residents gets a chance to learn this technique. We present a case illustrating the efficacy of the amobarbital interview in diagnosing and managing a case of conversion disorder with the goal to stimulate training in this vanishing art. Mr. X is a 62 year old male who presented with expressive aphasia. Mr. X initially had noticeable latency in his speech three days prior which worsened to not being able to remember simple facts and not being able to answer questions and express his thoughts. Mr. X had returned to work that week after taking four months off after having carpal tunnel release. He was forgetting customers’ orders and kept asking them to repeat it. He had a vacant look on his face and monotone voice, answering only “yes,” “no,” or “I don’t know.” He had difficulty reading, writing and in comprehension. Brain MRI, MRA of head and neck, lumbar puncture and EEG were negative. Urine toxicology, urinalysis, RPR and antinuclear Ab were negative. TSH and Folate was normal, but vitamin B12 was 187. The level was corrected with no change in symptoms. Due to negative anatomic and biochemical findings, Psychiatry was consulted. Due to the possibility of stress and anxiety, an amobarbital interview was conducted. 21 minutes into the interview, Mr. X began talking more fluently and verbally. He was able to read and recall events. He felt his thoughts were flowing more clearly and almost at baseline. His wife, who was in attendance throughout the procedure, confirmed that his statements were accurate and on topic. She was moved by some of the statements he made because he referred to things they had not discussed for many years. He felt guilty about being tough on an employee and helpless when he could not help his sister-in-law. Mr. X reported feeling stressed about returning to work because he did not like his job, but was worried about the financial problems they had had while he was on sick leave. Mr. X was followed up outpatient and treated with prn lorazepam 0.5mg. Mr. X reported doing well since leaving the hospital. He has since decided to retire and has been getting retirement benefits, which has relieved his financial stressors. He recalls all the events in the hospital, not being able to talk and express himself. He scored 27/30 on mini-mental state testing, missing three points on the delayed recall. We believe that the amobarbital interview provides a tremendous educational opportunity for residents to learn an effective diagnostic procedure, enhance interview skills, and learn more about psychodynamic processes. Unfortunately, it is becoming a lost art and most residents do not get an opportunity to learn and practice this procedure.

P2-10
ZOOPHILIA AND FETAL ALCOHOL SYNDROME IN AN ADOLESCENT: IS THERE A CONNECTION?

Lead Author: Richard Chung, M.D.

Co-Author(s): Gaurav Jain, M.D.; Pamela Campbell, M.D.; Sandra Vicari, Ph.D.

ABSTRACT:
Zoophilia or bestiality is a paraphilia that is rarely encountered in a clinical setting. Fetal alcohol syndrome has been associated with various behavioral disturbances, but there is a paucity of literature about its association with paraphilia in adolescence. A sixteen year old adolescent male, with a history of fetal alcohol syndrome and sexual abuse, was hospitalized because of worsening anger and impulsivity. The patient was engaging in sexual acts with pets and was putting foreign objects such as a toothbrush into his rectum. This behavior started six months prior with intense obsessional thoughts that were relieved by engaging in these acts. His laboratory tests were normal. On an IQ test he scored seventy eight and his working memory was in the mild mental retardation range. Psychological testing showed high impulsivity and hyperactivity. The literature shows an association of fetal alcohol syndrome with decrease in the size of corpus callosum, reduced volume of basal ganglia and cerebellum. These lead to persistent impairments in response inhibition, memory, and executive functions. Deficits in response inhibition imply limitations in the capacity for self control. Scanty literature points toward higher prevalence of inappropriate sexual behavior. We postulate that his history of sexual abuse superimposed on the brain damage caused by alcohol could explain his unusual behavior. Learning self-control is central to treatment which may be enhanced by both individualized therapy and medications. However, memory deficits may limit one’s capacity to participate in therapy and learn adaptive behavior. The patient was treated with fluoxetine and aripiprazole along with behavioral and cognitive psychotherapy. The patient responded to treatment and he felt his paraphilic urges and obsessional thoughts were better controlled.

P2-11
PRISM REGISTRY: A NOVEL TOOL TO ASSESS THE PREVALENCE OF PSEUDOBULBAR AFFECT SYMPTOMS

Lead Author: David Crumpacker, M.D.

Co-Author(s): Jonathan Fellus, MD; Daniel Kantor, MD; Benjamin Rix Brooks, MD; Randall E Kaye, MD

ABSTRACT:
Objective: To assess the prevalence of pseudobulbar affect (PBA) symptoms across 6 underlying neurologic conditions in a clinical practice setting. To evaluate the impact of neurological condition on patient quality of life (QOL), and use of antidepressants and antipsychotics in patients with and without PBA symptoms.

Background: PBA is a neurologic condition characterized by uncontrollable, inappropriate outbursts of laughing and/or crying. PBA occurs secondary to a variety of neurological conditions. While estimates of US prevalence of PBA may be as high as 2 million persons; the condition is thought to be under-recognized and often confused with depression. The PBA Registry Series (PRISM) was established to provide additional data from a “real-world” clinic sample.

Methods: US healthcare practitioners treating patients with

neurological conditions commonly associated with PBA were invited to participate. Institutional Review Board approved investigators were asked to enroll ?20 consenting patients with any of these 6 conditions: Alzheimer's disease (AD), amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson's disease (PD), stroke, or traumatic brain injury (TBI). Patients (or their caregivers) completed the Center for Neurologic Study–Lability Scale (CNS-LS) to screen for PBA symptoms; patients were not screened for other psychiatric disorders. The CNS-LS is validated as corresponding to physician diagnosis of PBA in ALS and MS at scores ?13 and 17, respectively. For PRISM, presence of PBA symptoms was defined as a CNS-LS score ?13. Patients also rated the impact of their neurological condition on QOL using an 11-point scale (0-10). Demographic data and current use of antidepressant/antipsychotic medications were also recorded.

Results: PRISM enrollment closed in September 2012 with 5290 patients. The overall prevalence of PBA symptoms (CNS-LS ? 13) was 36.7% (n=1944), and was highest in the TBI group (52.4%) and lowest in the PD group (26%). Patients with PBA symptoms reported greater impact of their neurological condition on QOL vs those with CNS-LS <13 (6.7 vs 4.7; P<0.0001); QOL scores by disease group were: AD, 6.4 vs 4.3; ALS, 6.4 vs 5.8; MS, 7.0 vs 5.2; PD, 6.4 vs 5.2; stroke, 6.7 vs 4.5; TBI, 6.8 vs 4.7 (P< 0.0001 for all except ALS [NS], two-sample t-test). More patients with PBA symptoms were using at least 1 antidepressant or antipsychotic medication vs those with CNS-LS<13 (43.9% vs 30.4%); AD, 50.3% vs 33.8%; ALS, 44.6% vs 31.9%; MS, 40.4% vs 32.7%; PD, 41.1% vs 22.5%; stroke, 41.3% vs 27.4%; and TBI, 43.0% vs 30.6% (P<0.0001 for all except ALS [NS], Chi-square).

Conclusions: PRISM is currently the largest clinic-based study to assess PBA symptom prevalence. PBA symptoms were common and CNS-LS scores ?13 were associated with impaired QOL and greater use of antipsychotic/antidepressant medications. The data underscore a need for greater recognition and diagnosis of PBA in at-risk patients.

P2-12
MUSIC AS AN AID FOR STUDYING AND CONCENTRATION IN ATTENTION DEFICIT DISORDER

Lead Author: Dennis Kuo, B.S., M.Sc.

Co-Author(s): Aimee Dereczyk, BS; Gregory C. Mahr, MD

ABSTRACT:
Introduction & ***Background:*** Attention deficit disorder is an increasing public health concern, now affecting 9.5% of children, with 30-70% of patients having symptoms into adulthood. Besides pharmacological interventions, a variety of psychotherapeutic and behavioral interventions have been attempted. Music as a complimentary modality in the psychotherapeutic treatment of patients with ADD has been frequently proposed.

Question & Significance: It remains controversial whether music helps concentration during attempts to study or serves as a distraction. While some literature on the "Mozart effect" suggests that listen to music by Mozart prior to completing certain mental tasks may enhance performance, other studies have found listening to music detrimental. The question thus remains whether or not music can provide beneficial effects in performing tasks that require concentration and attention. More significantly, would music have a beneficial role in non-medical management of the attention span for ADD?

Materials and Methods: Naturalistic study utilizing web-based data. Original music samples fulfilling specific musical criteria were released by the primary author onto a media-streaming website. Data from the web statistics and feedback from listeners were collected and reviewed.

Results: Over a 3 year period, the music has received more than 8 million "hits." A random sample of 340 comments left by listeners was reviewed; of these comments, 141 were excluded because they were unrelated to the music. Of the 199 remaining comments, 88.0% were positive. 47.4% of these positive comments specifically indicated greater concentration, less anxiety, and improvements in their studies, with 4 comments specifically mentioning ADHD/ADD. Other web-based analytical feedback derived from an online satisfactory rating system indicates an overall 96.0% positive feedback of the music (n=33,568). Currently, the website has gained more than 35,000 unique registered users. Based on the prevalence of ADD in the general population, 3,325 of the registered users might be expected to have ADD and to have found benefit from the music.

Discussion: This naturalistic study suggests that music with specific features may help students study, including students with ADD. The authors also describe key features of the music that may make it effective as an aid in concentration. The sheer volume of hits suggests, by the "wisdom of the marketplace," that music of the right form and type may be a useful study aid to those with ADD, warranting a necessity for further study.

P2-13
CASE REPORT: SYNAGOGUE ATTENDANCE BY AN ULTRA-ORTHODOX JEWISH MALE WITH BIPOLAR DISORDER

Lead Author: Aryeh Dienstag, M.D.

Co-Author(s): Aaron Pinkhasov, M.D.

NEW RESEARCH POSTERS

ABSTRACT:
Case: Our patient was a 27-year-old Orthodox Jewish Male with a history of Bipolar disorder. He presented with grandiose delusions of becoming the next Messiah as well as other symptoms of mania. On admission our patient refused to take medication or comply with the therapeutic milieu. The patient was verbally abusive towards staff and his abuse focused around the failure of staff to recognize his particular religious mission. Staff was faced with dilemma as the patient demanded to attend Synagogue services on Saturday, a practice prescribed by Orthodox Judaism.

Discussion: Psychiatric patients clearly have a right to exercise their religious practices and allowed to attend religious services. This issue is a complicated one and has not been fully discussed in the literature. There is no evidence that religious ritual contributes to the development of Symptoms of Mental Illness; although, when mental illness does exist, religion is a great place for the symptoms to hide (Greenberg and Witzum, Sanctity and Sanity, Yale University Press 2001). Our patient's psychopathology revolved around his religious beliefs. Due to poor insight he refused treatment and expressed wish to elope. Besides risk of elopement team also feared that attending religious services would reinforce his delusions and further hamper his recovery. However, the literature emphasizes the therapeutic value of religious observance on mental health as well. Patients often believe that it is abiding religious belief and spirituality that helps them recover from chronic mental illness (Talbott Journal of Nervous and Mental Disease, October 2012 p831). Religion has been listed as a protective factor against suicide (Caribe et al,2012) and it has been suggested attendance at religious services may be protective against mood disorders (Robinson et al, Anxiety and Depression Journal, November 2012, p983-90). However, medical professionals consistently overlook the importance of religion in the recovery of their patients (Goldfarb et al, American Journal of Drug and Alcohol Abuse, November 1996, p549-61). We were therefore hesitant to withhold from our patient the right to freely practice his religion and we were similarly reluctant to deny him the therapeutic value religion affords to many people suffering from mental illness. Our solution was to make the patient's attendance at Synagogue contingent on his engagement in his psychiatric treatment. This included an agreement to comply with treatment plan as well as adherence to medication regimen. He also agreed to be escorted to Synagogue to address risk of elopement. The patient did well on his trips to the synagogue and was eventually discharged back to his residence after a three-week stay in the hospital.

Conclusion: Addressing a patient's need to attend religious services can be an important part of mental health treatment plan based on therapeutic principles and safety precautions.

P2-14
TOTAL COST OF CARE AMONG PATIENTS WITH SCHIZOPHRENIA BY COST COMPONENT AND AGE

Lead Author: Maxine Fisher, M.D.

Co-Author(s): Kathleen Reilly, MA; Keith Isenberg, MD; Maxine Fisher, PhD

ABSTRACT:
Objective: To characterize real-world costs by service type and age among patients with schizophrenia.

Methods: Retrospective cohort analysis of patients (ages 13-64 with ?2 claims for schizophrenia) using commercial claims (HealthCore Integrated Research Database) from 1/1/2007-4/30/2010. Patients (N=5,676) were stratified by age: 13-17 (N=229, 4%), 18-25 (N=873, 15%), 26-35 (N=1,044, 18%), 36-45 (N=1,181, 21%), 46-55 (N=1,482, 26%), and 56-64 (N=867, 15%). Patients were followed from the first claim for schizophrenia (the index date) to 1 year. Antipsychotic medications were identified using the pharmacy claims closest to the index date (±90 days). Total annual all-cause and mental health-related costs, including all office visits, outpatient services, inpatient services, structured nursing, ER and pharmacy claims were calculated. Mental health services were defined by the presence of claims with ICD-9 codes 290.xx-316.xx and V40.x. Costs were described with means and standard deviations. Differences in mean costs were compared using ANOVA on log transformed costs.

Results: The total average annual all-cause healthcare cost for patients in the sample was $20,070±$32,434. Older age had a linear association with lower costs (P<0.01). Patients aged 13-17 had the highest total costs, $25,294±$42,619 compared to $20,723±$38,623 among patients ?55. Inpatient services represented the majority of total average costs at 43% ($8,668±$27,110), the majority of which were psychiatric (91%). Remaining total average costs by service type were: outpatient/office visits 28% ($5,595±$10,427); psychiatric pharmacy 20% ($3,955±$4,419); non-psychiatric pharmacy 5% ($1,414±$1,332); ER visits 2% ($440±$1,424); and structured nursing 1% ($142±$1,566). Across age groups, the percent of cost attributable to inpatient psychiatric stays was much higher for younger age groups, accounting for 51% of costs among patients <18 compared to 31% among those ?55 ($12,822±$39,006 vs. $6,516±$25,883); (P<0.01).

Conclusion: The main driver of healthcare costs among patients with schizophrenia is inpatient services. Although younger patients had higher antipsychotic costs, their higher total costs were mainly attributable to inpatient services. Treatments that reduce the number and length of inpatient stays, particularly among young patients early in the course

of disease, are likely to have the greatest impact on overall healthcare costs associated with schizophrenia.

P2-16
PILOTING PSYCKES: A RESIDENT-DRIVEN HEALTH SERVICES IMPLEMENTATION PROJECT

Lead Author: Miriam Galescu, M.D.

Co-Author(s): Abraham Taub, DO; Andrew Kolodny, M.D.; Theresa Jacob, PhD;, MPH

ABSTRACT:
Introduction: In academic medical centers, residents are at the forefront of implementing new and innovative systems for efficient patient care. Maimonides Medical Center, Department of Psychiatry hosted a pilot project of implementing the PSYCKES Medicaid Program (Psychiatric Services and Clinical Knowledge Enhancement System) in partnership with NYS Office of Mental Health (OMH). PSYCKES-Medicaid is a HIPAA compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the NYS Medicaid population. Our departmental leadership realized early on that residents would be the most frequent and proficient users of the PSYCKES database. Therefore, the residents were designated to pilot the project under the supervision of senior clinical faculty.

Objective: Our objective was to use the PSYCKES database systematically, evaluate technical glitches and provide feedback to the OMH team in order to make it more easily accessible and user-friendly.

Methods: During this 2-year project (Aug'10-June'12) our residents used PSYCKES to access information for our psychiatric emergency room patients. We provided feedback through weekly conference calls, monthly site visits and daily emails. Once the pilot phase ended, PSYCKES became available to all of our residents and training sessions commenced. When the PSYCKES database was made available to other hospitals, we participated in monthly collaborative calls and shared our experience in regard to the Consent Module, Recipient Search and how to make it a part of the medical record.

Results: This project was a fruitful collaboration between our hospital and OMH that improved the accessibility of the database by systematic feedback from the people 'on the front lines' – the residents. It proved the usefulness of data sharing through many clinical utilities, such as obtaining information on patient's medications, service providers and medical comorbidities. These further translated into superior medical care, cost-effectiveness and improved communication with outpatient providers. One of our most notable contributions was resolving the biggest rate limiting step of PSYCKES usage - the fact that it was only searchable by Medicaid ID numbers. After numerous conference calls and legislative consulting, our feedback prompted the development of a Social Security Number (SSN) based search engine.

Conclusions: The PSYCKES implementation project was a success, both for Maimonides Medical Center and OMH. There is unquestionable benefit in selecting residents to design and implement projects of which they will ultimately be the most frequent users. The outcome of our project will serve as guidance for other organizations looking to start pilot projects in academic medical centers.

P2-16
LISTENING TO OUR PATIENTS WHO CANNOT HEAR

Lead Author: Melissa Goelitz, M.D.

Co-Author(s): Claudia Reardon

ABSTRACT:
There are approximately 28 million people in the United States with some form of hearing loss, from mild to complete. An estimated 10% of that population relies on American Sign Language as its primary form of communication. Numerous studies cite a lack of appropriate education in caring for the Deaf/Hard of Hearing (HoH) population among healthcare providers, including mental health providers. This creates many barriers that prevent the proper utilization of health resources and leads to poorer health overall. Most research and interventions to date have not focused on training mental health professionals to cope with the needs of this community despite the population being at equivalent to higher risk for having mental illness than the general population.

A seminar was developed and presented by author, Deaf advocate and two interpreters representing the Wisconsin Deaf/HoH community which focused on increasing awareness of this community's communication needs and culture. Attendees (n=18) of the seminar completed surveys examining: confidence to provide appropriate care to Deaf/HoH individuals, confidence to appropriately diagnose their mental illness, and comfort in working with sign language interpreters. The scores were from very confident (1) to entirely not confident (5). Number of patients seen and their roles within the clinic setting were also recorded.

There was significant improvement in confidence to provide appropriate care with post-pre difference, -.650+-.996 (mean+-SD), p=.0165. There was no significant improvement in confidence to appropriately diagnose, -.29+-1.16, p=.31. There was no significant improvement in confidence in working with interpreters, -.41+-1.00, p=.11. Number of patients seen and role do not affect the difference in score. This project suggests that a seminar on working with Deaf/HoH patients may be effective in improving mental health providers' awareness of their skills and deficits. Future projects include expanding this educational module to other settings including presenting at local schools, working with an area crisis service line to expand their services offered, and collaborating with other residency programs to include this training in their residency.

P2-17
WHY DON DRAPER MATTERS: BRANDING AND MARKETING AN ACADEMIC PEDIATRIC SPECIALTY CLINIC

Lead Author: Robert Friedberg, Ph.D.

Co-Author(s): Lisa C. Hoyman, B.S.; Barbara A Friedberg, MBA

ABSTRACT:
Academics have much in common with entrepreneurs. Specialty clinics within academic settings are born to serve the behavioral healthcare needs of a well-defined population, provide robust training opportunities for supervisees, and produce new research. Adopting an entrepreneurial stance toward these endeavors increases the likelihood of success. Ideally, this entrepreneurial stance is punctuated by an appreciation of marketing and branding strategies. Accordingly, this poster offers several practical marketing and communications approaches specifically designed for professionals interested in developing a specialty center for treating anxious youth. The poster integrates proven brand marketing strategies within mental health service promotion. Ways mental health practitioners can promote their services to a targeted population are listed. Creative ways to use traditional marketing strategies and social media are presented. Finally, recommendations help the practitioners' patient base access self-help and educational materials are described.

P2-18
PREVALENCE OF PSYCHIATRIC DISORDERS IN PERINATALLY-INFECTED, HIV-POSITIVE CHILDREN

Lead Author: Mehr Iqbal, M.D.

Co-Author(s): Burhanullah, M.H., M.D.; Mani S; Isawi D; Minasourial

ABSTRACT:
Background: Mental health problems during adolescence place youth at a heightened risk for chronic mental health disorders and risky sexual behavior in adulthood Among the behavioral health risks shared by both groups of youth, mental health problems were the most prevalent for perinatally exposed HIV+ (PHIV+) youth. The prevalence of mental health problems in our study is greater than expected relative to surveys in the general population, but comparable to the few studies of children living with perinatal HIV infection or uninfected children living with HIV+ infected caregivers.

Methods: In a review of eight studies examining DSM-IV defined psychiatric disorders in HIV + youth (ages 4-21) high rates of psychiatric disorders were found in these youth groups, significant for: ADHD – 29%, Depression – 25% and Anxiety – 24%. Results were compiled specific to child psychiatric disorders, anxiety and behavioral disorders were the most frequent co-morbidity.

Results: Anxiety disorders included social and specific phobias, separation anxiety, agoraphobia, GAD and OCD. Perinatally HIV+ (PHIV+) youth were three times more likely to report a mood disorder and two times more likely to report ADHD compared to perinatally HIV- (PHIV-) youth. Overall, the literature review indicates both PHIV+ and PHIV- youth had extremely high rates (~70%) of any psychiatric disorder in one point in time or the other (either at baseline, or through follow up). These rates are also similar to those reported in the IMPAACT study in which 61% of both PHIV+ and PHIV- youth presented with a psychiatric disorder at one point of time. Taken together, these findings suggest that PHIV+ youth are at high risk for mental health problems. These results may be due to the psychosocial stressors associated with youth. Having HIV or being in a household with HIV-infected caregivers, rather than the biological course of HIV itself.

Conclusion: The prevalence of any psychiatric disorder significantly decreased in PHIV+ youth whereas for PHIV- youth, the prevalence of any disorder remained the same and mood disorders increased over time. These data suggest that perinatal HIV infection may not increase the risk of psychiatric disorders as these youth age, but access to treatment may be one explanation for the decrease in disorders as most PHIV- youth have been engaged in comprehensive HIV programs throughout their lifetime, typically attending clinics every 1-3 month and interacting with a large variety of healthcare providers. Furthermore, children with HIV infection have additional risk factors for mental illness, including forced disclosure of HIV status to others, including fear of progression to AIDS, and body image concerns resulting from delayed development, chronic dermatologic conditions or lipoatrophy. Moreover, infected HIV+ youth and the possible types of evidence based treatments needed to reach this select group of individuals.

P2-19
PERCEPTION OF PSYCHIATRY AND INDIVIDUAL LEARNING EXPERIENCE: A SURVEY OF MEDICAL

STUDENTS' OPINIONS

Lead Author: Joanna Kowalik, M.D., M.P.H.

Co-Author(s): Jennifer Weller, Ph.D.

ABSTRACT:
Objectives: The recruitment of medical students into the field of psychiatry is a pertinent topic and one with ramifications for the future of the field. Several studies have indicated that a psychiatry clerkship may favorably influence students' attitudes toward psychiatry; these attitudes are a positive outcome indicator of the clerkship's quality. The clerkship experience also creates the potential for psychiatry to become a career choice for medical students. Using a 17-item questionnaire, we assessed impressions of psychiatry rotation quality, individual learning experiences, and perceptions of psychiatry among medical and physician assistant (PA) students from a variety of United States and Caribbean medical schools.

Body: Ninety-four students from a diverse set of medical schools rated quality of clerkship and learning experiences using an anonymous self-report questionnaire following completion of the rotation. Items included ratings of the quality of the clerkship (e.g., organization, lectures, and feedback from preceptors), individual learning experiences on rotation (e.g., involvement in patient care, opportunities for observation, quality of preceptors, independent patient exposure), and psychiatry-specific education (e.g., exposure to a variety of psychiatric illnesses, the functioning of behavioral health systems of care, being an advocate for individuals with mental illness). Students were also asked if their perception of psychiatry as a medical specialty changed during their rotation. Additional information about the experience was gleaned from comments provided by medical students at the end of the survey. Comments frequently mentioned the value of one-on-one experiences with the preceptor. Ratings of 3rd year medical students (n = 67) from several schools resembled ratings of PA students (n = 13) from one specific medical school. All students agreed or strongly agreed that the quality of the psychiatry clerkship was excellent. Students moved from relative uncertainty during their 2nd and 3rd years to greater certainty about their choice of psychiatry as a medical specialty by the 4th year. Due to affiliation agreements, three medical schools provided the greatest number of students. A comparison of item responses showed different patterns of ratings among 3rd and 4th year students from these institutions. Overall, most students expressed that their perception of psychiatry changed during the rotation.

P2-20
PROVIDING CULTURALLY SENSITIVE CARE TO A TEENAGE PATIENT WITH PSYCHOSIS AND CATATONIA

Lead Author: Gaurav A Kulkarni, M.D.

Co-Author(s): Adam, Balkozar, M.D.

ABSTRACT:
Background: The impact of culture in psychosocial development has long been studied. Erik Erikson in his work on psychosocial stages highlighted the contributions from a biological and psychosocial standpoint [1]. We believe culture plays a key role in the developmental stages and the understanding of one's own illness. We discuss a patient who presented with psychosis and catatonia.

Case: The patient is a 16-year-old Muslim female who was brought to the emergency room by her parents because she was not eating, sleeping or speaking for 3 days. They moved from Somalia to the United States about 6 months prior as refugees. Since then, they reported that her personality had changed and described her as "odd and irregular." There is no history of sexual abuse or physical abuse; she denied having any depressive, anxiety, psychotic or manic symptoms.

Results: During the first day at the hospital, she appeared confused and mumbled to herself. She was pacing at times and spent most of the time standing. On the third day, she complained of hearing voices and couldn't sleep because of them. She seemed paranoid, looked around and didn't respond to any questions. Aripriprazole 1 mg daily was started, which was titrated up to 2.5 mg q daily. Lorazepam 0.5 mg bid was also added to help with the anxiety.

Discussion: Many refugee children experience adverse psychological outcomes during the resettlement period [2]. When delivering mental health services to immigrants, research reflects the importance of providing culturally sensitive care. For our patient, we were able to connect her with a mental health worker who is a first-generation immigrant and who shares some of the same cultural and religious beliefs. She was able to communicate, establish a rapport in a non-judgmental way and showed the patient that she respected her values and beliefs. All of this helped the patient and her family overcome a sense of shame they said they initially felt when their daughter was involuntary admitted. In addition, they were able to trust the diagnosis and the treatment, which included the use of medication – something they had never tried before. The patient's refusal to eat the hospital food sparked a health concern. She lost weight and had low potassium, so a Muslim dietitian was called in. The patient began by eating pre-packaged food in sealed containers to help with her paranoid thinking. With time, she was able to trust the staff and eat hospital food. To continue providing culturally sensitive care, the patient was assigned a Muslim psychiatrist for outpatient follow-up.

Conclusion: This case illustrates the diagnostic and treatment selection challenges in providing culturally sensitive care for patients with mental health issues, as well as cultural and language barriers. Considering the dearth of data, continued reporting of cases will be useful in understanding the complexities in tailoring care.

P2-21
A TEENAGER'S BREAKUP BY STATUS UPDATE AT FACEBOOK: AN INTENSE PERCEPTION OF PUBLIC HUMILIATION LEADING TO SUICIDE ATTEMPT

Lead Author: Salman Majeed, M.D.

Co-Author(s): Rabia Salman, MBBS; Muhammad Zeshan, MBBS

ABSTRACT:
Evolving era of social media has added new challenges to a person's sense of self as well as relationships with others. Complexity of living public lives has been acquiring new depths and demands closer observation to fully comprehend it's impacts.

Here we present a case of a teenager who endured trauma of breakup from her boyfriend through Facebook status update. In her own account, it was intolerably shameful to imagine what her Facebook friends will think of her unlovability and incompetence. Sense of humiliation in front of "everyone" was much more intense than losing her young love. Rather than seeking support from some friend, she immediately overdosed on Tylenol.

There is scarcity of literature on this topic, and traditional grieving of loss of the relationship isn't enough anymore.

P2-22
RELATIONSHIP BETWEEN SELF-ACTUALIZATION AND ANTICIPATED BENEFITS OF CARE IN PSYCHIATRIC TREATMENT

Lead Author: Matej Markota, M.D.

Co-Author(s): Andre R. Alexander, BS; Charles D. Hanson, M.D.

ABSTRACT:
Investigated the relationship between measures of self-actualization and optimism for psychiatric treatment outcomes with 22 psychiatric patients who completed the Short Index of Self-Actualization and the Anticipated Benefits of Care. Anticipated Benefits of Care scores were significantly ($p < .001$) negatively correlated to the Self-Actualization item, "I have no mission in life to which I feel especially dedicated". Total scores of the two constructs were significantly ($p = .040$) correlated, supporting the contention that self-actualized individuals are more optimistic about their psychiatric treatment. A significant ($p = .020$) effect of race was found whereby Latino subjects were less self-actualized and less optimistic about psychiatric treatment than white subjects. Implications for clinical psychology and psychiatric treatment are discussed (potential benefits and mechanism of combined treatment).

P2-23
EFFECTIVENESS OF IMMUNITY-TO-CHANGE COACHING FOR LEADERSHIP DEVELOPMENT

Lead Author: Inna Markus, ALM

ABSTRACT:
This study is the first formal, quantitative investigation of the effectiveness of Immunity-to-Change coaching for leadership development. The Immunity-to-Change coaching approach is a professional development framework that aims to increase clients' effectiveness in their professional roles by exploring the discrepancies between their current behaviors and intended goals. As in cognitive behavioral therapy, coached individuals uncover the underlying assumptions or cognitive patterns that give rise to these discrepancies, allowing clients the opportunity to envision and experiment with new, more effective behaviors. In this study, 45 Supervisors who engaged in Immunity-to-Change coaching were compared with a comparison group of 25 Supervisors from the same company to determine whether coached participants reported more progress on their personalized leadership development goals than did comparisons. The question of whether perceived likelihood of achieving one's goals increased with the coaching was also assessed. Finally, coached participants indicated their likelihood of utilizing Immunity-to-Change tools to pursue further goals and identified the coaching components they found most useful. Extensive analyses revealed that the coached group reported significantly more progress toward their leadership development goals than their comparison group counterparts. Despite having an extra month to actively work on their goals, comparison group participants were not able to make a comparable amount of progress toward their goals as the group who completed a round of Immunity-to-Change coaching. In fact, the comparison group did not make any statistically significant progress toward their goals, despite reporting that they actively worked on those goals for an average of 37.5 hours each within the 3-month comparison period. On the other hand, the coached group, who underwent approximately 22 hours of Immunity-to-Change coaching, reported an average improvement of 69.17%, as measured by retrospective self-reported progress toward their goals. Despite making significantly more progress on their goals than the comparison group, coached group participants were no more confident in their perceived likelihood of achieving their desired goals in the future than those who did not participate in the coaching. Finally, a vast majority (93%) of coached participants indicated intent to

use Immunity-to-Change coaching tools again in the future, especially the Four-Column Map.

P2-24
ERP-QEEG AS A PREDICTOR OF RESPONSE TO PHARMACOLOGICAL TREATMENT OF PATHOLOGICAL IMPULSIVE AGGRESSION IN YOUTH: A RETROSPECTIVE STUDY

Lead Author: Daniel Matthews, M.D.

Co-Author(s): Glenda W. Matthews, M.D.; Larry Fisher, PhD

ABSTRACT:
Prior investigations of the predictive value of QEEG for selecting psychopharmacological treatment have found little or no clinical utility (Crumbley, DeFippis, Dsurney, & Sacco, 2005). Recently, an Event-Related Potential method of QEEG (ERP-QEEG) has been used to select pharmacological treatment for impulsively aggressive juveniles (Matthews, Fisher, & Matthews (2012); Fisher, Ceballos, Matthews, & Fisher, 2011). The current study is a retrospective study of the clinical utility of the ERP-QEEG for selecting pharmacological treatment. Participants were 618 impulsively aggressive juveniles (416 male, 202 female; ages 5-17) treated in a residential treatment center and discharged on a medication protocol concordant with ERP-QEEG predictors. A mail survey of caregivers, at 6 months post-discharge, showed that 190 had changed protocols based on physician preference (Discordant-group) and 47 (24.74%) of those required re-hospitalization, while for the 428 still using the ERP-QEEG predicted protocol (Concordant-group), only 40 (9.25%) required re-hospitalization. Using a 2x2 Chi Square, two tailed, Fisher's Exact Test, there was a significant (p< 0.0001) relationship between concordance and re-hospitalization. While this is not a randomized controlled trial of the concordant protocol, the results suggest that, for this population, using the ERP-QEEG as a predictor of response to pharmacological treatment may have clinical utility.

P2-25
CAN PERICALLOSAL LIPOMA INCREASE PERSONAL VULNERABILITY TO PSYCHOTIC SYMPTOMS?

Lead Author: Askar Mehdi, M.D.

Co-Author(s): Ahmed Albassam, M.D.

ABSTRACT:
Objective: The association of Pericallosal lipoma and onset of Brief psychotic episode triggered by work related stress and sleep disturbance.

Design: Single case report.

Methods: Retrospective case study

Findings:A 30 year old Hispanic married woman presented with disorganized thoughts and behavior that presented after patient worked for five days in a row, 16 hours shift and reporting early insomnia with four hours of sleep each day. Patient on fifth day started exhibiting disorganized behavior, rambling loudly and expressing the need to write things down that were not making any sense. Patient also reported having auditory hallucination, non command type of her coworkers. Patient was hospitalized for stabilization of acute psychotic symptoms. Patient received oral risperidone as primary treatment and haloperidol with lorazepam as needed for agitation. Patient reported resolution of symptoms with in 48 hours. To rule out neurological cause of new onset psychosis, CT scan of brain was done and a lipoma of the Corpus Callosum was found, described as a parafalcine fatty mass adjacent to the rostrum of the Corpus Callosum. On further questioning Patient reported that was an incidental finding in 2006 after patient sustained a head trauma following a motor vehicle accident. Patient had no history of substance use and reported no familial predisposition of psychiatric illness.

Conclusions: Defect in Corpus Callosum morphology has been associated in literature with Schizophrenia. We reported case with brief psychotic episode that was likely predisposed by lipoma of corpus callosum and precipitated by work related stress and sleep disturbance. Further studies are required to find out the causative factors and to highlight any preventive measures that can be taken to avoid such episodes in the future.

P2-26
EFFECTS OF COGNITIVE ENDEAVOR ON CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AND THETA/BETA RATION IN THEIR EEGS

Lead Author: Jeongha Park, M.D.

Co-Author(s): Se Hee Kim, M.D., Ph.D.; Gi Jung Hyun M.D.; Churl Na, M.D., Ph.D.; Doug Hyun Han M.D., Ph.D.

ABSTRACT:
Introduction: In the review of EEG in children with attention deficit hyperactivity disorder (ADHD), elevated theta power and reduced relative alpha and beta power have been suggested. In addition, several stimulants would change the EEG pattern of frontal lobe in children with ADHD. During 8 weeks working memory stimulation (Baduk), we assessed the changes in attention symptoms, cognitive function, and EEG pattern in drug naïve children with ADHD.

Methods: Eleven drug naïve children with ADHD and eighteen age and sex matched healthy comparison subjects were recruited. During 8 weeks, both ADHD without medication and healthy children were asked to play go (Baduk) for four hours/day with instructor of the art of Baduk. Before and at the end of 8 weeks playing go period, clinical symptoms, cognitive functions, and brain EEG were assessed with Dupauls' ADHD scale (ARS), digit span, Trail making test-B, and 32-channel TC EEG system (B.E.S.T medical systems, Wien, Austria).

Results: There were significant improvements of ARS total score (z=2.93, p<0.01) and inattentive score (z=2.94, p<0.01) in children with ADHD. However, there was no significant change in hyperactivity score (z=1.33, p=0.18). There were improvement of digit total score (z=2.60, p<0.01; z=2.06, p=0.03), digit forward (z=2.21, p=0.02; z=2.02, p=0.04) in both ADHD and healthy comparisons. In addition, ADHD children showed decreased time of TMT-B (z=2.21, p=0.03). While healthy comparison subjects showed increased relative high-beta right (z=2.42, p=0.02) and decreased relative theta left (z=2.43, p=0.02), relative theta right (F=2.42, p=0.02), Theta/alpha left (z=3.88, p<0.01), Theta/alpha right (z=3.88, p<0.01), Theta/beta left (z=3.88, p<0.01), and Theta/beta right (z=3.88, p<0.01), children with ADHD showed decreased Theta/alpha left (z=3.32, p<0.01), Theta/alpha right (F=3.32, p<0.01), Theta/beta left (z=3.32, p<0.01), and Theta/beta right (z=3.33, p<0.01). The change of Theta/beta right in children with ADHD was greater than that in healthy comparisons (F=4.45, p=0.04). The change of right Theta/beta was positive correlation with ARS-inattention score and negative correlation with Digit forward score (r=-0.65, p=0.01) in children with ADHD (r=0.44, p=0.03).

Discussion: These results indicate that cognitive endeavor could activate hypoarousal brain in children with ADHD in terms of cognitive and brain activity pattern.

Education meaning: 1. In accordance with previous reports, elevated theta power and reduced relative alpha and beta, and theta/beta ratio supported hypoarousal theory for ADHD. 2. Cognitive endeavor could activate brain in children with ADHD.

P2-27
BULLYING VICTIMIZATION, MENTAL HEALTH PROBLEMS AND SUICIDAL BEHAVIOR

Lead Author: Pyung hwa Park

Co-Author(s): Jae Hong Park; Byeong Moo Choe; Seong Hwan Kim; Chang-yeop Kim

ABSTRACT:
Objective: Bullying involves repeated hurtful actions between peers where an imbalance of power exist (L. Arseneault, 2010). Bullying victimization warrants attention in the context of self harm among adolescents because of its association with suicidal behavior as well as with a wide range of mental health problems such as depression, anxiety (Elaine M. McMahon, 2010). School bullying victimization and suicide are key issues of mental health for Korean adolescents. Bullying victimization is a common problem among Korean adolescents, with prevalence of 14% reported in Korean middle school students (Young Shin Kim, 2005). The objectives of this study were to compare the mental health problems between bullied and non-bullied students and examine association between bullying victimization and suicidal behavior.

Methods: The data of this study comprises responses of students of the 7th, 8th and the 9th grade of 44 middle schools in Busan, Korea. Study procedure was as follows; first, all participants (n=26,092) were screened by using Korean version of Youth Self-Report (YSR). Students with a T-score ?60 on the total behavioral problem subscale of YSR were considered to be mental health risk group (n=1838). Next, we interviewed high risk group using Korean version of Kiddie-Schedule for Affective Disorders and Schizophrenia-Present and Lifetime Version. Bullying victimization and suicidal behavior were directly questioned during interviewing session. Finally 1,196 (male 544, female 652) middle school students completed the interview. The Institutional Review Board of Dong-A University Hospital approved the study.

Results: Of the sample of 1,196 students who completed diagnostic interview, 301 (25.2%) reported life time history of bullying victimization. Results of YSR scores showed that bullied students had significantly high scores of anxiety/depression subscale (t=5.8, p<0.001), internalizing problems subscale (t=5.8, p<0.001) and total behavioral problems subscale (t=5.1, p<0.001). In term of psychiatric morbidity, depression was more common among those students who were being bullied (?2=66.9 p<0.001). Multivariate logistic regression models found that bullying victimization significantly increased the likelihood of suicidal ideation (OR=1.7, 95% CI=1.3-2.3, p<0.001) and suicide attempts (OR=4.0, 95% CI=2.2-7.2, p<0.001).

Conclusion: Victims of school bullying had more severe mental health problems and higher risk for suicidal behavior. Results of this study underline the importance of bullying-prevention policies in schools.

P2-28
AUTONOMIC SEIZURES WITH PANIC DISORDER FEATURES

Lead Author: Abhishek Rai, M.D.

Co-Author(s): Dr. Babur Bhatti M.D.

ABSTRACT:
In this case write up, a patient who was initially diagnosed

with panic disorder and later found to have partial seizures are being described. Mr B is a 19 year old male with a history of sudden spells which lasted less than a minute. Prior to the spells starting, he would have strange tastes in his mouth and during the spell he was unable to speak or come up with words. He never lost consciousness and could have several spells a day. He did not have any psychiatric symptoms and his history was significant for recreational cannabis use. Initially he was given quietiapine, hydroxyzine, and clonazepam by the psychiatrist. However, given the stereotypic behavior and the prodrome of taste changes, the neurologist felt it was indicative of complex partial seizures and he was started on valproic acid.

Partial seizures and panic disorder often share similar features which can make diagnosis challenging. For example, during the prodromal period of seizures, patients can experience similar symptoms such as anxiety, depression, tension etc. Temporal lobe seizures are often characterized by autonomic symptoms similar to panic attacks such as changes in heart rate, blood pressure, etc. The features of both disorders will be described as well as an algorithm to differentiate the disorders. This paper will further consider syncopal attacks and psychogenic seizures to provide a complete differential diagnosis. It is important for the psychiatrist to identify features that warrant neurological or cardiac evaluation in these situations so patients can get the appropriate treatments.

P2-28
NONPSYCHIATRIC PHYSICIANS' ATTITUDES TOWARDS MENTAL ILLNESS

Lead Author: Savitha Rao

Co-Author(s): Rashi Aggarwal, M.D.

ABSTRACT:
Introduction: Stigma has been well documented to plague psychiatry as a field of medicine. It leads to poor patient care and decreased medical student recruitment. Patient care can be hindered because stigma may lead to problems for patients both personally and professionally. There has been research on medical student stigma towards mental illness and psychiatry, which suggests that a poor perception from non psychiatric physicians may deter medical students from pursuing psychiatry. We reviewed the research done on attitudes of non psychiatric physicians towards mental illness.

Method: A literature search was conducted on Pubmed and Google Scholar. The following MESH terms were used: stigma, attending physicians, attitudes, psychiatry, opinions, mental illness, bias. Cross checks of listed references were performed.

Results: Six articles were found that directly measured non psychiatric physician stigma against mental illness. They were all from outside the US, including Sri Lanka, UK, Israel, Japan, Italy, Nigeria and used self administered questionnaires filled out by physicians of different specialties and medical students. Comparisons between physicians and medical students did not seem to show a significant difference. Five studies investigated stigma against specific mental illnesses and found that the most negative attitudes were towards depression and schizophrenia. Two of those studies showed that physicians had personal difficulties treating depressed patients. Overall, the most consistently held negative attitude was unpredictability. Two studies investigated how physicians thought about the source of mental illness in regards to curability. One study showed that most physicians believed schizophrenia was genetic, which correlated to incurability. Another study showed that a majority of physicians thought that most mental illness is caused by alcohol and drug misuse.

Discussion: This literature review demonstrated that common negative attitudes are held by non psychiatric physicians towards patients of mental illness. These attitudes result from lack of knowledge about scientific evidence or cultural beliefs, both of which need to be addressed. Since no US study was found, the review demonstrated a need for a US study identifying stigma held by physicians towards mental illness. This stigma needs to be identified and addressed for successful patient care and medical student recruitment.

P2-30
ASSESSING CAREGIVER BURDEN IN CAREGIVERS OF PEOPLE WITH SCHIZOPHRENIA: DEVELOPMENT OF THE SCHIZOPHRENIA CAREGIVER QUESTIONNAIRE

Lead Author: Diana Rofail, M.D.

Co-Author(s): Diana Rofail, Chloe Tolley, Chris Marshall, Linda Abetz, Steven H. Zarit, Carmen Galani Berardo

ABSTRACT:
Introduction: Informal (unpaid) caregivers of people with schizophrenia may experience significant 'burden' in terms of the impact of caregiving responsibilities on their own daily lives, physical health and emotional well-being. The 22-item Zarit Burden Interview (ZBI) was originally developed to assess burden among caregivers of people with Alzheimer's Disease. Whilst the instrument has since been applied to assess burden of caregivers of people with schizophrenia, establishing the scale relevance and meaningfulness for use in this population is still required.

Methods: A targeted literature review was conducted in MEDLINE, EMBASE and PsycInfo to identify qualitative research articles outlining the experiences of caregivers of people with schizophrenia. Published research articles documenting the development, validation and use of the ZBI (in schizophrenia and other disorders) were also sought. Based on evidence derived from the literature, a review of the ZBI was conducted according to best practice guidelines for self-report measures (i.e. the FDA PRO Guidance for Industry). In particular, evidence for the face and content validity of the ZBI was closely examined. The results were used to inform initial modifications to the ZBI to ensure that the questions in the scale were relevant to caregivers of people with schizophrenia and captured all issues of importance to this population. The revised scale was then completed by 19 US English speaking caregivers as part of cognitive debriefing interviews designed to assess the relevance, comprehensiveness and ability of caregivers to understand the revised scale.

Results: The review resulted in several operational changes to the ZBI, including specification of a recall period ('during the past four weeks') and modification of response options (from a 5-point Likert-type scale to an 11-point numerical rating scale) to help increase sensitivity of the scale to changes in caregiver burden. Furthermore, minor alterations were made to the phrasing of existing items and ten additional items assessing key concepts for schizophrenia caregivers were included. Feedback from caregivers during cognitive debriefing interviews supported the content validity and relevance of the resulting instrument (the Schizophrenia Caregiver Questionnaire), with scale instructions, items and response options being well understood by caregivers.

Conclusion: The 32-item Schizophrenia Caregiver Questionnaire, developed in accordance with best practice for PRO measures and with insight from caregivers of people with schizophrenia, demonstrates strong face and content validity. However, future research designed to establish the psychometric validity of the instrument is needed to confirm its adequacy to assess burden experienced by caregivers of people with schizophrenia in clinical research and practice.

P2-31
"SOMETIMES IT'S DIFFICULT TO HAVE A NORMAL LIFE": A QUALITATIVE STUDY EXPLORING CAREGIVER BURDEN IN INFORMAL CAREGIVERS OF PEOPLE WITH SCHIZOPHRENIA

Lead Author: Diana Rofail, M.D.

Co-Author(s): Diana Rofail, Chloe Tolley, Chris Marshall, Linda Abetz, Steven H. Zarit, Carmen Galani Berardo

ABSTRACT:
Objectives: Informal (unpaid) caregivers play an important role in the care of people with schizophrenia. As a disease typified by early onset and chronic course, caring for a person with schizophrenia may significantly impact the 'burden' experienced by caregivers in terms of their daily lives, in terms of physical health, and emotional well-being. To date, there has been limited exploration of caregiver burden via qualitative research. This study investigated the experiences of caregivers of people with schizophrenia to inform the development of a conceptual model that would provide a holistic overview of 'caregiver burden' in this population.

Methods: Face-to-face qualitative semi-structured interviews were conducted with 19 US English speaking caregivers of people with schizophrenia. Sampling quotas were employed to ensure representation of a diverse sample of caregivers in respect of: age; gender; ethnicity; relationship to the person with schizophrenia; cohabitation status with the person with the schizophrenia; and the severity and manifestation of the care recipient's schizophrenia symptoms. Questions were asked in an open-ended and non-leading manner to facilitate spontaneous reporting. Interview transcripts were analyzed using a data-driven empirical approach based on grounded theory methods. Findings were used to inform the development of a conceptual model providing a visual representation of the holistic experiences of caregivers of people with schizophrenia (including impact on daily lives, physical health and emotional well-being) in the context of disease presentation and treatment outcomes.

Results: Findings support assertions that caring for a person with schizophrenia has a significant impact on numerous facets of caregivers' lives. As documented in the newly developed conceptual model, care recipients were largely dependent upon caregivers for the provision of care and, as a result, caregivers reported lacking time for both themselves and their other responsibilities (e.g. family and work). Caregivers frequently reported feeling 'alone' in their role as a caregiver and the burden experienced frequently manifested as detriments in physical (e.g. fatigue, sickness) and emotional (e.g. depression and anxiety) well-being. Positive elements of caregiving (e.g. relationship with care recipient), however, were emphasized by study participants and are also highlighted within the conceptual model.

Conclusions: Caring for a person with schizophrenia has a wide and far reaching impact on the lives of informal caregivers. Alleviation of caregiver burden therefore may be an effective means of reducing the individual and societal costs associated with schizophrenia. Future research should focus on establishing reliable and valid means of assessing burden among caregivers of persons with schizophrenia to inform the development and evaluation of interventions for reducing this burden.

P2-32
MENTAL HEALTH EDUCATION AND ADVOCACY IN GHANA

Lead Author: Paul R. Sachs, Ph.D.

Co-Author(s): Kwame Sanahene, BSc; Akwasi Osei, M.D.; Abayomi O. Ige, M.D.

ABSTRACT:
Ghana is one of the most politically stable and economically vibrant countries in Africa. The country was one of Africa's first democracies and is known for its stable transfer of power. Historically, however, people in Ghana with severe mental health problems were regarded with fear. Their families, sensitive to the public stigma, kept them out of sight. People with mental illness were chained, beaten, starved and some committed to asylums with little opportunity for discharge. In May 2012, the Ghanaian government passed a progressive mental health bill that recognizes international best practices and yet has specific provisions for the local needs. Specifically the law declares and supports the rights of those with mental illness, provides for protection of vulnerable groups, establishes a rights monitoring committee, and a tribunal to investigate complaints. The law emphasizes community based treatment as opposed to institutionalization. It also recognizes the unique role of traditional healers while protecting against abuses (WHO, 2012). This law is a major step for the country. There remain, however, outstanding problems related to access to mental health care, low numbers of professionals, use of chemical restraints and little education of the general community about the causes and best treatment practices for mental illness. Similar problems existed in the USA in the twentieth century. Advances in medicine contributed to a change in the care of those with mental illness. At the same time, grass roots advocacy groups played a major role in the transition of American mental health care from an asylum-based to a community-based system of care. The present paper describes the development and activities of a Ghanaian mental health advocacy organization: "For All Africa Foundation (FAAF)" in promoting the principles of the Ghanaian mental health care law and the rights of those with mentally illness.

FAAF's core mission is: 1)To increase knowledge and skills about mental disorders and how they can be prevented and treated. 2)To support and empower anyone experiencing a mental health problem.

The evolution of FAAF is described including the role of the founder and current executive, involvement of local professionals and the group's education and outreach projects within the country. The unique aspects of mental health advocacy in Africa and developing countries are discussed including FAAF's role as a critic of government policy, and its efforts to debunk myths about mental disorders and address the role of native healers. Photographs and videos of FAAF's community advocacy and education efforts will be included in the presentation. The FAAF experience can be a model for the development and work of other mental health advocacy organizations in developing countries in Africa and elsewhere. *New mental health law passed in Ghana (2012, Summer). mhGAP news, WHO. From: www.who.int/mental_health/mhgap/en/

P2-33
IS OCULOMOTRICITY A GOOD MARKER OF MPH EFFICIENCY IN ADHD?

Lead Author: Magali Seassau, Ph.D.

Co-Author(s): Roberta Carcangiu; Thomas Weiss; Fabrice Duval

ABSTRACT:
Background: Attention-Deficit/hyperactivity disorder (ADHD) is characterized by behavioral symptoms of inattention and may include hyperactivity and impulsivity. The impulsivity and inattention suggest deficits in the voluntary control of behavior. Eye movements depend on structures implicated in attention and in motor control, both criteria areas of dysfunction in ADHD. In the present study, objective was to evaluate the effect of methylphenidate (MPH) using oculomotricity in ADHD children.

Methods: Subjects were aged 7-12 years, with ADHD on and off MPH (N=9), and control subjects (N=9). Saccade latencies, precision, accuracy and percentage of anticipatory errors were determined in automatic attentional tasks (visually-guided-saccades) and voluntary attentional tasks (overlap, antisaccades and fixations tasks).

Results: Significant differences existed between ADHD on MPH and ADHD off MPH, in latencies ($p<0.02$), precision ($p<0.04$), accuracy ($p<0.05$) and percentage of anticipatory errors ($p<0.05$). Compared to controls, ADHD on MPH had normalized performances in automatic task, while they still impaired in voluntary attentional tasks.

Conclusions: MPH modified motor planning and response inhibition in ADHD children. Benefits depend of the type of tasks, automatic and voluntary attention. These results suggest that eye movements could be a good marker of MPH efficiency in ADHD.

P2-34
PROMOTING RESEARCH AND SCHOLARSHIP IN JUNIOR RESIDENTS

Lead Author: Steven Goldfinger, M.D.

Co-Author(s): Mohamed A. Sherif, Ellen J. Berkowitz

ABSTRACT:
Providing an environment which supports a spirit of academic inquiry, imparts competencies in critical thinking and scientific methodology, and promotes residents' productivity as scholars is an area of training that is frequently overlooked or given only passing attention. SUNY Downstate instituted a multifaceted model designed to address these issues with minimal expense while exposing residents to several components of academic scholarship.

There are five core components to this approach.

1- Designation of a Chief Resident for Research and Academics

2- Implementation of a course on research methodology

3- Allocation of a one month research rotation in the PGY2 year

4- Assignment of ongoing research mentorship for the remainder of the residency

5- Mandatory supervised review[s] of Journal article[s] during and after research month

Chief Position

The qualities needed for this position span a number of areas, including familiarity with the different research opportunities available, both clinical and basic science, the ability to mentor and guide residents, and the facility of critical appraisal. This position has multiple components including: 1- Research mentorship, identifying residents' interests and career goals;2- Matching interests with laboratory and/or supervisor;3- Execution and follow up of the research plan and solving problems that might arise during such interaction 4-Overseeing the manuscript review process

Implementation of a course on research methodology

The course includes an introduction on how to formulate a research question and design a study to test the hypothesis; IRB and ARB training, and meetings with experienced researchers who provide insights into their research. The course is led by senior researchers and co-instructed by the chief resident.

Allocation of a one month research rotation in the PGY2 year

PGY-2 mentorship starts with a presentation for the rising PGY-2s describing the various research opportunities available. This is followed by individual meetings with the chief and the Chair to further discuss and consolidate their research plans. The chief resident follows up with the resident on the execution of the research plan.

For those with little interest in research, this may be an academic review or case study. Foremost, however, the month serves as a preliminary intensive exposure to a project which often spans the next two years. All residents are expected to present their research either as a journal article, a poster, or a formal presentation.

Assignment of an ongoing research mentorship for the remainder of the residency

As noted, most residents begin to gather background information for their research project prior to their research month. Approximately 90% of them continue to work with a mentor through, and sometimes after, graduation.

P2-35
CHILDHOOD DISINTEGRATIVE DISORDER: CASE REPORT AND REVIEW OF LITERATURE

Lead Author: Manan Jayvant Shah, M.D.

Co-Author(s): Vishal Madaan, M.D.

ABSTRACT:
Objectives: a)Understand the rare presentation of and common comorbidities associated with childhood disintegrative disorder (CDD); b)Review the diagnostic dilemmas and management strategies for individuals with CDD.

Abstract: Childhood disintegrative disorder (CDD) is a rare condition of unknown etiology characterized by regression of language, social function, and motor skills after a period of fairly normal development during the first 2 years of life. CDD, also known as Heller's syndrome, is a devastating condition with poor prognosis, affecting both the family and the individual's quality of life, often resulting in permanent disability. Pooled prevalence for CDD is reported at about 1.7 per 100,000, and predominantly affects males. We describe the case of a 5-year-old boy with Attention Deficit/Hyperactivity Disorder who presented with speech delay and regression of developmental milestones. He began to have increasingly aggressive behavior about a year ago, along with acute changes in motor skills that led to multiple falls, changes in his ability to climb stairs, increased clumsiness and inability to use utensils. This was accompanied by changes in language skills including impaired ability to make specific sounds and use of a lot more "baby talk". Over the next few months, he lost diurnal & nocturnal control of bladder and bowel. On exam, he was of small stature and had facial asymmetry with skull flattening on one side and hemi-hypertrophy on the other side of his body. A brain MRI revealed plagiocephaly while an EEG and metabolic workup were normal. Initially, he received intensive in-home behavioral therapy that did not help

with the aggressive behaviors. His aggression and irritability improved somewhat with long acting methylphenidate and long acting clonidine, and he continues to be followed. Given that CDD is a poorly understood condition with no clear-cut treatment and poor prognosis, management involves a detailed work-up, followed by supportive care and often symptomatic treatment. A significant percentage of patients have seizures and hence, an EEG is an important component of the work-up. Metabolic disorders such as mucopolysaccharidoses & lipid storage disorders and neurological disorders such as SSPE & tuberous sclerosis have been associated. Landau-Kleffner syndrome, another rare condition with seizures and loss of language skills should also be considered. A detailed cytogenetic evaluation is recommended in all subjects with CDD, especially those with intellectual disability, abnormal EEG patterns, seizures, muscular hypotonia, severe motor & gait problems or dysmorphic features. Parents & guardians must be adequately supported as they often are sole caregivers of affected children. Behavioral treatment strategies, like Applied Behavioral Analysis, are often used to shape appropriate behavior, while psychotropic medications and anti-epileptics are the mainstay for managing aggression & seizures respectively.

P2-36
KNOWLEDGE, ATTITUDES AND BELIEFS OF GRADUATE MEDICAL TRAINEES IN PSYCHIATRY TOWARDS THE DSM-5

Lead Author: Manan Jayvant Shah, M.D.

Co-Author(s): Vishal Madaan, M.D.

ABSTRACT:
Introduction and Objectives: With a variety of changes proposed in the diagnostic criteria in the upcoming DSM-5, it is important for psychiatrists to stay abreast of this progress in psychiatric classification. Despite the potential impact of these changes in clinical practice, research, training, and even reimbursement, psychiatry trainees may have little awareness of the new proposals. At the end of this poster session, participants will be able to appreciate the awareness of proposed changes in DSM-5 from a resident perspective, and understand the trainees' attitudes and impressions of the DSM-5 and its influence on their training and clinical practice.

Methodology: We designed this brief study to understand the knowledge, attitudes and beliefs of psychiatry trainees towards DSM-5, and to identify specific problem areas that could impede their understanding of such changes, followed by specific recommendations to rectify them. An anonymous survey, approved by the University of Virginia IRB for Social and Behavioral Sciences, containing about 20 questions, was administered online to current graduate medical trainees in general psychiatry and sub-specialty fellowships within the Commonwealth of Virginia. The sample included residents from Virginia Commonwealth University, University of Virginia, Carilion Clinic-Virginia Tech and Eastern Virginia Medical School. The study was approved by the local IRB in August 2012. Data collection began immediately after approval and will continue for 6 months.

Results: At the time of submitting this abstract, thirty-nine subjects had provided responses. Majority of the responders were PGY-4 residents (31%). About 60% responders believed that evidence based research and expert consensus will have contributed to majority of the changes in DSM-5. Interestingly, only 13% participants mentioned that they had received or were going to receive specific education about DSM-5 in their residency program. Almost half of the participants were unaware of the availability of preliminary draft revisions for public review. Almost all (97.5%) participants believed that the DSM-5 task force should publish a quick reference guide to summarize the major revisions after the publication of DSM-5.

Conclusions: There is limited awareness of the DSM-5 changes among current psychiatric trainees, despite DSM-5 field trials and updated draft revisions that have been available in public domain. The trainees anticipate a lot of changes, but feel unprepared and inadequately informed about them. There is a need for targeted education about DSM-5 in the present curricula of psychiatry trainees. Also, it would be worthwhile to publish a brief reference guide to summarize the major revisions in the new DSM compared to its previous version.

Authors: Manan Shah, M.D. and Vishal Madaan, M.D., University of Virginia Health System, Charlottesville, VA

P2-37
EFFICACY OF A SCHOOL-BASED INTERVENTION ON BEHAVIOR AND SELF-ESTEEM: CEDARS-SINAI'S PSYCHOLOGICAL TRAUMA CENTER'S SHARE AND CARE PROGRAM

Lead Author: Suzanne Silverstein, ATR

Co-Author(s): Reneh Karamians, MA; Enrique Lopez, Psy.D.; Anand Pandya, M.D.

ABSTRACT:
Introduction: Childhood psychological trauma is associated with a variety of negative health and educational outcomes but there is limited data on interventions to mitigate these outcomes. The efficacy of the Cedars-Sinai Psychological Trauma Center's Share and Care school based Mental Health program was evaluated with a diverse ethnic student population within the Los Angeles area schools.

Methods: Since the year 2000, students from elementary, middle and high schools who participated in the Share and Care program were assessed by their teachers using the Behavioral Academic Self-Esteem (BASE) rating scale (Coopersmith & Gilberts, 1982) at the beginning of each academic year. At the end of the school year the post-BASE was re-administered by the teachers for those participants who were in the program. A total of 1770 participated in a minimum of a 12-week Art Therapy structured group curriculum to deal with a traumatic event/stressor that has impacted their academic functioning.

Results: Hispanic and African American students had significantly greater improvements when compared to other ethnicities; however, all ethnic student groups improved after the intervention to varying degrees.

Conclusions: A structured, school-based intervention was beneficial with diverse ethnic populations that have suffered a traumatic event.

P2-38
EXCALIBUR: MULTI-AGENCY INTERVENTION AND SUPPORT BAROMETER

Lead Author: Samuel Stein, MBBCh FRCPsych

ABSTRACT:
Over the past decade, heavy criticism has been directed towards mental health and social care services for failing to manage children and families at risk more effectively. Unfortunately, traditional risk assessment tools have proved to generally be of limited usefulness, especially as they struggle to address multiple risks within a single measure and fail to facilitate effective communication between different professionals and agencies.

However, adverse health and care incidents can be reduced in frequency by sensible contingency planning, and risk assessment is therefore a national clinical governance expectation. Whilst all trusts are required to have a risk management strategy in place, this needs to be seen as the assessment of current or past situations, and not as a predictor of particular future events. Risk management should also be conducted in a spirit of collaboration with service user and their carers, building on their strengths and emphasising recovery. In contrast, defensive risk management has a poor user experience and poor user engagement, serving only to increase risk.

Recognising these problems, the Multi-Agency Intervention and Support Barometer has been designed to provide a unique but comprehensive approach to risk management. It utilizes a very broad-based clinical approach, in a user-friendly format, with major emphasis on intervention and recovery rather than on risk identification alone. The barometer also promotes follow-through from assessment to management, and provides effective communication across teams, services and agencies. In addition, the barometer allows for easy updating, and tracking of changes over time, with findings that can be reviewed as simple graphs. Emergency alerts are also automatically triggered when patients score very highly on the risk factors being measured.

If integrated into health and social care, the barometer will actively reduce risk whilst also providing essential support for vulnerable children and families. The aim of this presentation is therefore to highlight the underlying rationale behind the approach, and to provide detailed guidance as to how it can be implemented in both clinically effective and cost effective ways across a whole range of community settings.

P2-39
DISORGANISED CHILDREN: IDENTIFYING AND WORKING WITH SUBTLE NEURODEVELOPMENTAL DIFFICULTIES

Lead Author: Samuel Stein, MBBCh, FRCPsych

ABSTRACT:
"Disorganised children" are referred to child and adolescent mental health services due to concerns about emotional and behavioural problems, which occur both at home and at school. By this time, their presentation has often been attributed to underlying emotional problems, family difficulties, defiance and disobedience, oppositional attitudes, difficulties with authority or deliberate attempts to be anti-social and naughty.

Whilst these "disorganised children" present with elements of ADHD, autism and conduct difficulties, they often fail to meet the strict diagnostic criteria for a particular diagnosis. A definitive aetiology for their difficulties has not yet been identified and cannot be overtly demonstrated. However, their presentation is consistent with a probable neurological deficit which is of sufficient severity to cause demonstrable difficulties and yet of insufficient severity to be identified on investigative testing.

The aim of this paper is to highlight the needs of this very interesting and yet often overlooked group of children. It will be aimed at primary care and mental health professionals, as well as addressing educational and social issues. The paper will provide a general overview of similar neuropsychiatry conditions, and basic child development. This will be followed by a description of "disorganised children", and comparison with established diagnostic categories in child and adolescent mental health. Finally, principles of management will be tackled in a way that will be of benefit to professionals from a wide range of disciplines.

P2-40

ASSOCIATION OF SPIRITUALITY AND MENTAL HEALTH IN AN OHIO ARMY NATIONAL GUARD SAMPLE

Lead Author: Marijo B. Tamburrino, M.D.

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ABSTRACT:
Introduction: As concerns rise about suicide rate and the mental health of our military forces, factors that promote resiliency are being sought. Although much has been written about spirituality as a coping mechanism in the civilian population, including religiosity being associated with lower depression levels, there are limited studies in military samples. The current study explores the association of spiritual well-being with selected mental conditions in a military sample.

Methods: Data was analyzed from a population-based sample of 418 Ohio Army National Guard (OHARNG) soldiers who participated in a telephone survey that assessed PTSD (17-item PCL), Depression (PHQ-9), Alcohol Use Disorders (MINI 14-item scale) and Suicidal Thoughts (PHQ-9). Participants also completed demographic questions and a 20-item self-report instrument, the Spiritual Well-Being Scale (SWBS). The SWBS measures overall spiritual quality of life and has subscale scores for existential well-being (EWB), religious well-being (RWB), and spiritual well-being (SWB). Subscale scores of the SWBS were summed and split into high and low well-being scores based on the median value. Chi-square tests were performed to compare proportions of mental health conditions within strata of high compared to low SWB, EWB, and RWB.

Results: 355 of the 418 subjects who agreed to participate completed all the survey questions. Participant demographics matched those of the overall OHARNG in being primarily male (87.9%), white (90.3%), ages 17-34 years old (65.4%) and married (52.7%) Overall, high SWB scores were associated with lower prevalence of depression in the past year [4.97% (N=9) vs. 17.24% (N=30), p<0.01], lower prevalence of Alcohol Use Disorder (AUD) in the past year [6.08% (N=11) vs. 13.22% (N=23), p<0.01] and lower prevalence in the past year of any (>1) mental health condition, including PTSD, Depression, AUD or Suicidal Thoughts [14.92% (N=27) vs. 29.89% (N=52), p<0.01]. Prevalence of PTSD alone or prevalence of suicidal thoughts alone were not associated with SWB scores, or EWB and RWB subscale scores.

Discussion: Our main finding of high spirituality being associated with lower depression and alcohol use disorders has important implications, as these were the two most prevalent mental conditions in this study. More research is needed to understand the complexity of spirituality in the military, including interactions regarding deployment. The SWBS is an easily administered instrument (10 – 15 minutes to complete), which could be a helpful tool in assessing the spiritual resilience programs being developed by the military.

P2-41
SELF-INFLICTED STRANGULATION FROM THE "CHOKING GAME" NOT SUICIDE

Lead Author: Mehnaz Waseem, M.D.

Co-Author(s): Edward Hall, M.D.; Muhammad W Khan, M.D. MPH

ABSTRACT:
Introduction: Choking Game is a dangerous activity in which children deprive their brain of oxygen to achieve a natural high. It involves applying pressure by different objects like belts, hands, etc; to the neck to stop the blood flow to the brain and then releasing the pressure to create a temporary sense of euphoria. This game has been played in groups and individually.

The game become even more deadly, when youth play the game alone. The practice of self-strangulation resulting in death may have been more common in the past than it has been reported, because many such deaths may have been misclassified as suicides. e.g.; the Center for Disease Control and Prevention (CDC) reported that 82 individuals, between the ages of 6 years and 19 years old have died in a span of 12 years as a result of participating in the Choking Game.(from 1995 to 2007) .The Dylan Black Foundation, an awareness organization founded by a parent of a victim of the game, reported that in 2007 alone at least 45 deaths resulted from young people playing the game. The website, Games Adolescents Shouldn't Play (GASP), states that in 2007, the total number of deaths that year was at least 86.

Objective: Previous research has reflected that many of the physicians are not aware of the choking game. It has also been reported that deaths from choking game are misclassified as suicide. This case report aims to raise the awareness about Choking Game among physicians and to avoid misclassifying choking game related accidental deaths as suicide.

Methods: Case report & Literature review

Case: The patient was a 14-year old African American female with no prior psychiatric diagnosis, who was brought to the Bergen Regional Medical Center emergency room for making several attempts to hang herself. Pt. attempted to hang herself using a belt and an ID band around neck. During the stay in the hospital patient expressed that her behavior was not a suicide attempt but was self asphyxiating herself to enjoy the feeling attached with it.

Result: The adolescence is the age where children are curious, impulsive and are risk taking. The literature review regarding choking game has revealed that only few of the parents of children who died were familiar with the choking game. It is to emphasize that parents, educators, and health-care providers should learn about the choking game and be able to recognize any of the warning signs in youths

Conclusion: By learning about the different names, risk factors and warning signs of the choking game, parents, educators, and health-care providers may be able to identify youth at risk for playing the game and prevent future deaths. In addition, better mortality surveillance is needed, and more research should be conducted to determine prevalence, risk factors, and protective factors that will lead to effective interventions aimed at reducing or eliminating choking-game participation and deaths.

P2-42
MENTAL HEALTH SERVICE UTILIZATION AMONG DETAINED ADOLESCENTS: A META-ANALYSIS OF PREVALENCE AND MODERATOR FACTORS

Lead Author: Laura M White, M.S.

Co-Author(s): Matthew C. Aalsma, PhD; John H. McGrew, PhD; Michelle P. Salyers, PhD

ABSTRACT:
Objective: Research has shown high prevalence of mental disorders and substance use disorders among the detained adolescent population. Utilization of treatment services among this population is not well understood, with service utilization rates varying widely from 3% to 76% across studies. This meta-analysis was conducted to review and synthesize the current state of the literature regarding service utilization among detained adolescents.

Method: Studies about service utilization among detained adolescents were identified via computer searches, manual scanning of reference lists, and correspondence with authors of relevant studies. Data from studies were abstracted and coded. Thirty-one studies of 33 distinct samples totaling 21,039 adolescents were meta-analyzed using the Hunter & Schmidt (1990) approach to conducting a meta-analysis. Individual effect sizes were combined using random effects models to determine effect sizes for mental health and substance use service utilization, as well factors that moderate service utilization. Sub-analyses were conducted to identify significant differences in service utilization across groups.

Results: Prevalence effect sizes for service utilization were low, with main effect sizes ranging from r = 0.260 (CI = 0.18-0.36) for substance use services, r = 0.296 (CI=0.21-0.39) for mental health services, and r = 0.378 (CI=0.28-0.50) for both services. Significant heterogeneity was found across individual effect sizes and the moderator analysis identified several significant moderators of service utilization, including gender, race/ethnicity, service timing, service setting, study location, and date of study. Sub-analyses indicated that service utilization was significantly lower for detained males than females (OR=0.6 26, CI=0.518-0.757), and for Black detained adolescents (OR=0.430, CI=0.329-0.563) and Hispanic detained adolescents (OR=0.526, CI=0.368-0.752) than White detained adolescents. In contrast, service utilization was significantly higher for detained adolescents with mental disorders (OR=3.791, CI=2.834-5.07) and substance use disorders (OR=1.916, CI=1.412-3.216) than other detained adolescents.

Conclusions: Findings suggests poor service utilization, as well as significant gaps and disparities in treatment services for detained adolescents. Future research should focus on addressing the treatment needs of detained adolescents, improving treatment services within correctional facilities, and enacting programs to ensure consistent identification, referral, and connection to care for detained adolescents.

P2-43
JUVENILE DETENTION-BASED MENTAL HEALTH SERVICES: TREATMENT BEYOND DELINQUENCY

Lead Author: Cheryl D. Wills, M.D.

Co-Author(s): Mary Gabriel

ABSTRACT:
This poster will introduce the audience to the Cuyahoga County Juvenile Justice Mental Health Access Program (MHAP) Program, from conceptualization to early outcomes. The MHAP offers services to at-risk and justice-involved youths in an effort to limit the influence that untreated mental disorders can have on the youth development and rehabilitation. Juvenile justice-involved youths have higher rate of mental disorders than their peers in the general population. Caretakers of detained youths, including those youths who recidivate, report that the mental health care received by detained youths does not often continue when they are released to the community due to inadequate access to services. The MHAP was established to address this problem. The Program is a unique partnership between an academic teaching hospital, a community-based mental health organization, a county juvenile justice facility, and a county mental health board. The Program, which is located

on a safe, accessible juvenile justice campus, offers psychiatric services, mental health counseling, and case management services. The goal is to empower youths and their families by reducing the debilitating influence of childhood mental disorders and fostering prosocial youth behavior in the community. When the MHAP opened in November 2011 eight hours of mental health services were offered each month to justice involved youths. The Program now offers eight hours of services to youths each week, serves as a training site for child psychiatry residents and counseling interns, and has expanded to offer mental health services to at-risk youths who are not involved in the juvenile justice system as a form of early intervention.

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P2-44
INTERNATIONAL MEDICAL GRADUATES' EXPERIENCE IN PSYCHIATRY RESIDENCY

Lead Author: Chunying Xu, M.D., Ph.D.

Co-Author(s): Balkoski, Victoria M.D.; Lukowitsky, Mark PhD; Motenko, Jill PsyD

ABSTRACT:
Objective: Considering that 41% of psychiatry residents are International Medical Graduates (IMG's), the understanding of IMG's training experience cannot be ignored. This study focuses on exploring and understanding the experience of IMG's in a psychiatry residency program by examining the themes of lived phenomena. This might increase awareness of cultural differences and enhance the learning experience of this group in order to meet their educational needs.

Method: The current study applied interpretive phenomenological research (qualitative design) to explore the training experiences of IMG's in a mid-sized psychiatry residency program. Nine IMGs (PGY I through PGY IV) from 8 different countries of origin participated in semi-structured interviews with a single investigator (CX). Interviews were subsequently transcribed in order to analyze significant statements, meaning units, and textural and structural descriptions

Results: An interpretive analysis of the interview responses reflected both common and specific themes of IMG experiences. Qualitative themes ranged from interactions with patients, staff, peers and medical students to issues affecting self perception, self identity, satisfaction, acculturation process, and attitude.

Conclusions: The individual experiences in psychiatry residency training reported by the IMGs in this sample suggested several relevant themes. An analysis of these themes suggested that attitudes, acculturation, language skills, individual strengths, personal experiences prior to residency, and issues related to the cultural sensitivity of the residency program may all contribute to the IMGs' ability to successfully adapt in their residency program. Moreover, a greater understanding of these factors by residency programs may augment the learning process, facilitate growth and personal identity, and improve the overall quality of the IMG experience.

P2-45
INTEGRATING MENTAL HEALTH INTO SCHOOLS: A NIGERIAN EXPERIENCE

Lead Author: Maymunah Yusuf Kadiri, M.B.B.S., FMCPsych

ABSTRACT:
Background: Nigeria is a middle income country with only about 160 qualified Psychiatrists for a 160million Nigerians, this means 1 per 1million as compared 1 per 10 thousand in the UK and 1 Psychiatric Nurse per 50 thousand Nigerians. Mental health is not part of the Nigeria school curriculum. Stigma remains a serious problem, with many cases of human rights violations, such as, chaining or beating, experienced by people with mental illness. Less than 3% of Gross Domestics Product is budgeted to health and less than 1 % goes to mental health. The Lunacy Act of 1958 is what it's in use in Nigeria because the Mental Health bill has not been passed by the National Assembly.

Objective: School based mental health programmes is an innovative mental health promotion program which provides a framework for mental health promotion in Nigerian schools. Its objectives are to facilitate exemplary practice in the promotion of whole-school approaches to mental health promotion; develop mental health education resources, curriculum and professional development programs which are appropriate to a wide range of schools, and to encourage the development of partnerships between schools, parents, and community support agencies to promote the mental wellbeing of young people.

Method: A team of mental health experts, supported by a reference group of academics and health education professionals, developed School based mental health programmes. The programs so far have been piloted in 4 schools, drawn from all educational systems.

Results:The program provides a framework for mental health promotion in widely differing school settings. The teacher professional development dimension of the program is central to enhancing the role of schools in broad population mental health promotion.

Conclusions: Promoting the mental health and wellbeing of all young people is a vital part of the core business of teachers by creating a supportive school environment that is conducive to learning. Teachers need to be comfortable and confident in promoting and teaching for mental health. Specific, targeted interventions, provided within a whole-school framework, address the needs of the minority of students who require additional support.

Keywords: Health-promoting schools, mental health education, wellbeing, whole school approach, young people.

P2-46
PREFRONTAL CORTEX, SCHIZOPHRENIA, AND ADDICTION AND THEIR ASSOCIATION WITH POOR PROGNOSIS: A LITERATURE REVIEW

Lead Author: Jamsheed H Khan, M.D.

Co-Author(s): Anthony Kelada

ABSTRACT:
The prefrontal cortex corresponds to Broadmann areas 8, 9, 10, 11, 12, 13, 44, 45, 46, and 47 (20). This region of the brain has tremendous implications on ourselves, our youth (2), and in addiction (3). It plays a part in multiple psychiatric disorders, of which schizophrenia will be discussed here. It is also implicated in craving and drug seeking (44). The ventral tegmental area of the brain contains dopaminergic projections which go to the prefrontal cortex and amygdala, and plays a critical role in shaping drug-seeking behaviors (42-43). Furthermore, it is the dopamine hypothesis that has led to the advent of 2nd generation antipsychotics in treatment of psychotic disorders, including schizophrenia.

Orbitofrontal damage results in deficits of maternal behavior, emotional functioning, and empathy, including complex social events and linking them with their emotional value (23). Similarly, patients with schizophrenia have decreased social cognition. This may be due to direct or indirect altercation of their orbitofrontal cortex. They may exhibit antisocial behaviors such as shoplifting, sexually aggressive behavior, and reckless driving. Possible manifestations of schizophrenia that can lead to these actions include voices telling the patient to do these activities, or simply a byproduct of disorganized behavior.

prefrontal cortex disruption can affect a wide range of behaviors, many of which are seen in patients with schizophrenia. Another role of the prefrontal cortex that has been implicated in psychopathology it its role in addiction. Imaging studies in addictive behaviors have identified a key involvement of the PFC both through its regulation of limbic reward regions and its involvement in higher-order executive function, like self-control and awareness (3).

Conclusion and Future Implications: Schizophrenia is a debilitating disease that often carries a poor prognosis. Perhaps the most comprehensive method of treating schizophrenia is by thinking via the prefrontal cortex. Not in its singularity, but rather as a region which has circuits connecting to other regions of the brain, like the hippocampus involving memory and the cerebellum with motor movements. We know that antipsychotics and cognitive behavioral therapy both treat schizophrenia, and as shown by neuroimaging studies, both affect the metabolic activity of the prefrontal cortex. Additionally, addiction and risk taking involves the prefrontal cortex, and we know that schizophrenia patients are likely to also have substance use disorder, a risk-taking behavior. It is recommended to integrate substance abuse treatment with schizophrenia (32).

P2-47
COMBINED PSYCHOLOGICAL-OPIATE INTERVENTIONS REDUCE PTSD SYMPTOMS IN PEDIATRIC BURN PATIENTS

Lead Author: Frederick J. Stoddard Jr, M.D.

Co-Author(s): Laura D. Stone, MA: Atilla Ceranoglu, M.D.; Erica Sorentino, MA; David S. Chedekel, Ed.D.; J. Michael Murphy, Ed.D.; Robert L. Sheridan, M.D.; Ronald G. Tompkins, M.D., Sc.D.

ABSTRACT:
Infants and toddlers account for 50% of all pediatric burn injuries, but few studies on post-traumatic outcomes have included pre-school children. Hypothesis: This study examined the hypothesis that the combined effect of psychosocial interventions for caregivers and pharmacological interventions with young burned children would reduce PTSD symptoms. ***Method:*** The key measure analyzed was the Posttraumatic Stress Disorder Semi-Structured Interview and Observational Record (PTSDSSI) (Sheeringa, 2003). This semi-structured interview for caregivers contains all of the DSM-IV PTSD diagnosis items, as well as appropriate developmental modifications to assess PTSD in preschool age children. ***Results:*** One-way ANCOVA model was calculated using the patient's follow-up PTSD score as the dependent variable with the independent variable being

whether or not they received the psychological intervention. The covariate for this model was the patients' baseline PTSD scores, which statistically controlled for preexisting differences in the baseline scores. After analyzing psychosocial and opioid interventions, n of 30, the results showed reduction (p=.04) in mean follow-up PTSD scores (psychosocial & medication M=of 3.62 to medication alone M=1.55). ***Conclusion:*** These results support the hypothesis that combined interventions are superior to medication alone. Future research with larger samples is needed to optimize treatment for young children with severe trauma.

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FRIDAY, OCTOBER 11, 2013

POSTER SESSION 3

P3-01
NUTMEG FOR MY DEPRESSION

Lead Author: Melissa Begolli, M.D.

Co-Author(s): Mekabiz Abaian,M.D.; Brian Ladds, M.D.; Celia Purugganan, M.D.

ABSTRACT:
Introduction: This is a case of a patient who used intranasal nutmeg to relieve his symptoms of depression.

Case Description: Mr. S is a 19 year old Bangladeshi man who was seen at the psychiatry outpatient clinic with symptoms of depression and self-harming behavior. He denied symptoms of mania. He questioned his religion and felt no purpose to life. With his last psychiatric hospitalization occurring after an overdose on his psychiatric medications. He denied history of drug abuse, and toxicology was negative. He was on olanzapine 10 mg daily, citalopram 40 mg daily and clonazepam 1 mg tid. After 5 months of ongoing treatment he denied feeling depressed and attributed the change in mood to his adherence with medications. It was learned that the patient was snorting ground nutmeg at home. He reported that he read on a website that nutmeg might help with his depression. He could not determine the exact amount but his brother reported that in 4 days he used half a bottle of nutmeg through intranasal administration. He was observed to be happier and more energetic at that time.

Discussion: Nutmeg, a commonly used as a cooking spice, is a product of the nutmeg tree, "Myristica fragrans." The seed of the tree is termed nutmeg. It contains myristicin, which is a non-selective MAO inhibitor, (1,2). Some investigators studied the extract of Myristicin fragrans which elicited a significant anti-depressant-like effect in mice. The anti-depressant effect was proposed to be a result of the interaction of the extract with adrenergic, dopaminergic, and serotonergic receptors (2). One author proposed that the psychoactivity, including euphoria and psychosis, might be due to the metabolic conversion of myristicin to amphetamine-like compounds (3). There are reports that myristicin is closely related to an analog of ecstasy (MMDA), affecting serotonin and to a compound with hallucinogenic effects similar to LSD (4). The psychic effects of nutmeg have been described by well-known authors. William Burroughs, the famed author of the Beat Generation, wrote that the Indians of South America used nutmeg by sniffing to achieve certain mental effects (5). Malcolm X wrote about his experiences while in prison using nutmeg, comparing its effects to marijuana (6). The famous anatomist Dr. Purkinje ingested nutmeg and recorded hallucinations and a sense of euphoria that lasted for several days (7). Several cases report people using nutmeg in order to cause euphoria (8). Nutmeg has been described by some as an hallucinogen, causing visual hallucinations, agitation and dissociation (9).

Conclusion: This report is one of the few cases reported in the literature that demonstrates the use of ground nutmeg to alleviate depressive symptoms, resulting in an increase of levels of energy, better concentration and mood. Additional investigation is needed to elucidate the role of nutmeg (myristicine) as an MAO inhibitor.

P3-02
EFFICACY AND HEALTH ECONOMICS COMPARISON OF TRANSCRANIAL MAGNETIC STIMULATION (TMS) AND ANTIDEPRESSANT DRUGS IN THE TREATMENT OF MAJOR DEPRESSION

Lead Author: Dafna Bonneh-Barkay, M.Sc., Ph.D.

Co-Author(s): Mark A. Demitrack, David G. Brock, Ziad Nahas, Kit N. Simpson, Annie N. Simpson

ABSTRACT:
Background: Transcranial magnetic stimulation (TMS) is a safe and effective antidepressant treatment for those unable to benefit from initial antidepressant medication. Clinical outcomes of patients treated with the NeuroStar TMS Therapy ® in a multisite, naturalistic, observational study (Carpenter et al. 2012) were compared to a propensity-matched group of patients who participated in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study.

Methods: Groups were matched on measures of gender, age, income level, treatment resistance staging, symptom burden (QIDS-16 scores), and functional status (SF12 physical and mental component scores). Propensity score matching was performed using a Greedy Algorithm approach to select a STAR*D comparison group with similar baseline characteristics to the matched NeuroStar TMS patient population. A logistic regression model was used for constructing propensity scores, and a 1:1 population matching was completed. Clinical outcomes were then compared at a standard time point of 6 weeks exposure to either NeuroStar TMS or STAR*D medication assignment between groups. Outcome categories were defined using standard severity cut-points established for the QIDS-16.

Results: Propensity score matching of the NeuroStar TMS and STAR*D patients demonstrated no statistically significant baseline differences between the two groups. Mean standardized differences between cases and controls after matching were less than 0.25 for all variables, which is the commonly accepted threshold for good matching. The mean (SD) QIDS-16 score at the 6 week timepoint was 10.4 (6.18) vs. 13.0 (4.57) for the NeuroStar TMS and STAR*D groups, respectively (p<0.0001). At baseline, 69.4% and 72.2% of patients were categorized as severely ill or worse (QIDS-16 >15) for the NeuroStar TMS and STAR*D groups, respectively. At the six week timepoint 27.0% of the NeuroStar group vs. and 5.2% of the STAR*D group were categorized as with no symptoms (QIDS-16 score <6). Bootstrapping was employed to examine the effect of variations in matching on the clinical estimates.

Conclusion: Propensity score matching methods were successfully used to create a pseudo-randomized comparison population to allow a comparison of clinical outcomes of naturalistic treatment of patients with pharmaco-resistant major depression with either TMS or medication treatment. The results indicate that TMS achieved a greater proportion of patients with full symptom benefit at a fixed observation time point of 6 weeks of treatment compared to medication treatment as usual.

P3-03
A CASE OF LITHIUM INHALATION

Lead Author: Carmen Casasnovas, M.D.

Co-Author(s): Dara Fernandez, M.D.; Raj Addepalli, MD; Brian Ladds, M.D.

ABSTRACT:
Introduction: A few cases of lithium misuse have been reported in literature. This is a case of lithium being used via the intranasal route.

Case Presentation: 20 year old man, with history of bipolar disorder; PCP abuse; and Cannabis dependence; multiple psychiatric hospitalizations; not adherent to medications. He presented to the ED, aggressive and psychotic. He stated "snorting" lithium at home. Lithium level was 0.22mleq/L. It is unclear whether patient only used lithium intranasally or if he supplemented with oral dosing. Also unclear is the time between dose and measure of level. He was admitted to a psychiatric facility. He was seen in the ED less than a month later with same chief complaint and again reported smoking cannabis and "snorting" lithium. He stated it was like "cocaine" to him. All laboratory testing was normal.

Discussion: Inhaling lithium is very rare. A review of the literature (Pubmed) revealed no cases. Its "snorting" use has been a topic on web forums and discussion boards.The literature revealed 2 cases of oral lithium use for recreational purposes. In the British Medical Journal (1977), in a letter to the editor, there is a report of patients who abused lithium, though the route of abuse was not specified, and the author did not know why this substance was being abused (1). In a Letter to the Editor in the American Journal of Psychiatry (1988), there is a report of a patient taking up to 2400mg/ day of lithium "for a buzz." He augmented lithium with coffee as it " relaxed him" and led to feelings of light-headedness and giddiness. After taking this combination a number of times, he was admitted to the hospital with lithium intoxication (lithium level of 3.0 meq/liter). (3) The route and method of drug administration influences biodistribution, bioavailability, and elimination of the drug (4). For drugs taken intranasally, the absorption rate and extent is affected by the fineness of the particle size in crushing a tablet. Though unsure of the particle sizes inhaled by this patient, it is possible that it was heterogeneous, and was distributed throughout the airway tract.

Conclusion: Lithium is a very uncommon substance of abuse, and all the more so through an intra-nasal route. It could be abused for desired CNS effects or it is possible that a person may be self-administering lithium to help regulate mood. The patient presented here may have used lithium via intranasal route because this was a route he was familiar with in his use of cocaine. He may have used it to diminish mood symptoms, and possibly, to bring this about rapidly, for either empirically demonstrated reasons or based on his perceptions of how quickly cocaine works. Although we note his sub-therapeutic level, it might have become therapeutic in the course of time.Clinicians should be aware of this issue, especially in patients who 'snort' cocaine.

P3-04
HEALTH COACHING AND VIRTUAL VISITS IN THE COLLABORATIVE CARE OF DEPRESSION

Lead Author: Trina Chang, M.D., M.P.H.

Co-Author(s): J. Benjamin Crocker, David Judge, Ryan Sherman, Anne Huppert

ABSTRACT:
Depression is one of the most common chronic conditions encountered in primary care, affecting about 10% of patients. Yet it is often under-recognized and under-treated, in part due to providers' relative inexperience in diagnosing, discussing and managing the disorder, insufficient time to address the issue during a standard office visit, and lack

of access to mental health care oversight with specialists. Depression has a profound impact on functioning, quality of life, and health care costs. If not managed effectively, depression can negatively impact outcomes of other chronic medical conditions such as hypertension, cardiovascular disease, diabetes, obesity, orthopedic issues, chronic pain, and malignancy.

Extensive evidence supports the effectiveness of the IMPACT model for the collaborative care of depression in primary care for improving depression outcomes and reducing costs. Current directions of research and evaluation are focusing on dissemination and implementation in clinical settings as well as adaptation of the model for working with other, possibly more complex populations.

The goal of this pilot was to adapt and evaluate a depression collaborative care program based on the IMPACT model, using our Health and Wellness Coach as the care manager. The Health Coach employed motivational interviewing and goal management skills to manage problems such as diet, exercise, weight loss and smoking cessation, in addition to depression. Our program also allowed the health coach and primary care provider to conduct "virtual" (telephone or e-mail) visits to monitor patients.

We tracked referrals, visits, and depression outcomes using the Nine-Item Patient Health Questionnaire (PHQ-9). In the pilot's first year, 30 patients with depression were referred and 27 (90%) were enrolled; the average PHQ-9 score on enrollment was 11.0. The average number of Health Coach visits per enrolled patient was 4.42, with 53% being virtual visits. The 90-day depression remission rate was 68%, and the 180-day remission rate was 73%.

Our experience demonstrates the successful implementation of a primary care team-based depression collaborative care model using an innovative Health Coach role, with outcomes comparable to published results. This unique Health Coach role could enhance the effectiveness and reach of a collaborative care model, enabling patients to simultaneously address multiple health challenges. Our pilot also confirms the effectiveness of virtual care in chronic disease management and paves the way for future cost-effectiveness evaluation. These features highlight the cornerstones of a patient-centered medical home model of chronic disease management and may suggest a strategy that would allow primary care practices to provide highly integrated care for patients with depression and multiple medical comorbidities.

P3-05
ILLNESS BELIEFS OF DEPRESSED CHINESE AMERICANS IN A PRIMARY CARE SETTING

Lead Author: Justin Chen, M.D.

Co-Author(s): Galen Hung, M.D., MS; Albert Yeung, M.D., ScD

ABSTRACT:
Despite its well-known contribution to poor health and quality of life outcomes, unipolar depression remains underrecognized and undertreated. In the US, underutilization of mental health services by the populations with greatest need is significantly compounded among ethnic/racial minority groups, particularly Asian Americans. Prior research indicates that culturally determined explanatory models of illness shape help-seeking behavior, suggesting that investigating the relationship between Asian Americans' illness beliefs and mental health service utilization is an important area of inquiry. The current investigation is the first large-scale descriptive study of the illness beliefs of depressed Chinese American primary care patients using a standardized instrument. Chinese American patients who sought primary care at South Cove Community Health Center in Boston were randomly approached and screened for depression using the Chinese translation of the Beck Depression Inventory. A diagnosis of major depressive disorder was confirmed with the Structured Clinical Interview for DSM Disorders. Of those who screened positive, 189 patients completed an assessment of their illness beliefs using the Explanatory Model of Interview Catalogue, a validated semi-structured interview tool that probes five dimensions of illness beliefs: chief complaint, conceptualization and labeling of illness, perceptions of stigma, causal attributions, and help-seeking patterns. Subjects' responses were sorted into discrete categories by independent raters for the purposes of descriptive analysis. This poster will present the results of this study, including the distribution of chief complaint, name of problem, stigma score, perceived cause of problem, and preferred help-seeking methods identified by the Chinese American subjects. It will also report the association between stigma scores and reported perceived cause as well as preferred help-seeking methods. Future studies should compare these results with subjects of similar socioeconomic status but differing ethnic background, as well as assess the influence of acculturation status on illness beliefs, and influence of illness beliefs on the course and prognosis of illness.

P3-06
WORK-LOSS DAYS OF COMMUNITY DWELLING ADULTS WITH DEPRESSIVE DISORDERS AND DEPRESSIVE SYMPTOMS IN KOREA

Lead Author: Maeng Je Cho, M.D.

Co-Author(s): Sohn Jee Hoon; Seong Su Jeong; Park Jee Eun; Ryu Ji Min

ABSTRACT:
Purpose: To explain this unexpectedly low prevalence of major depressive disorder, despite the high suicide rate, we examined the functional disability and quality of life in community-dwelling subjects with significant depressive symptoms not diagnosable as depressive disorder.

Methods: A total of 1,100 subjects, randomly chosen from catchment areas, were interviewed with the Center for Epidemiologic Studies Depression scale, Mini International Neuropsychiatric Interview, and the WHO Disability Assessment Schedule. Those with scores over 21 on the depression scale were interviewed by a psychiatrist for diagnostic confirmation.

Results: The 1-month prevalence of major depressive disorder was only 2.2%, but the 1-month prevalence of depressive symptoms under the diagnostic threshold of major depressive disorder or dysthymia was 14.1%. Depressive disorders were causes of 24.7% of work loss days, while depressive symptoms not diagnosable as depressive disorder were causes of 17.2% of work loss days.

Conclusions: Significant depressive symptoms below the threshold of a DSM-IV diagnosis of major depressive disorder or dysthymic disorder are prevalent in Korea, and cause substantial loss of everyday functions and quality of life in community. Only a small proportion of these depressive subjects in community can be diagnosed as having a DSM-IV depressive disorder. These findings support the dimensional approach to depressive disorder in the community and might be the missing link between the apparent low prevalence of depressive disorder and high suicide rate in Korea.

P3-07
FACTITIOUS DISORDER: A CASE OF AN EX-SERVICE VETERAN

Lead Author: Roberto Antonio Cruz B., M.D.

Co-Author(s): Amin Hedayat, Msc; Rita Gonzalez, M.D; R.A.; Melissa Begolli M.D; Raj Addepalli M.D; Carlos Carvajal, M.D.; Vyas Persaud, M.D..

ABSTRACT:
The authors present a case of factitious disorder. The factitial presentation involved an ex-service veteran with claims of PTSD who upon investigation was found to have never been involved in combat. The magnitude of factitious combat-related PTSD and the motives which lead people to take on a victim role are discussed. As much as veterans are to be taken at face value in terms of symptoms described especially when related to PTSD, it is important to keep in mind factitious disorder or malingering as a possible differential diagnosis. Close observation, previous medical records and collateral information is of true value for this difficult diagnosis.

P3-08
GRAY MATTER ABNORMALITIES IN PATIENTS WITH FIRST-EPISODE MANIA, WITH AND WITHOUT A HISTORY OF A PREVIOUS DEPRESSIVE EPISODE

Lead Author: Nadeesha L Fernando, B.Sc., M.D.

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ABSTRACT:
Introduction: There is growing evidence that structural alterations exist in the brains of patients with bipolar disorder. In patients with first-episode mania, the magnitude of these alterations appears to be smaller than in patients with a longer history of bipolar illness. However, about 60% of patients with first episode mania have a history of previous depressive episodes and it is currently unknown if magnitude of structural brain changes is different in those with and without a history of depression compared with healthy controls. The objective of this study therefore was to use 3T MRI to ascertain structural brain changes in these two subgroups of first episode manic patients in comparison to healthy controls.

Material and ***methods:*** Magnetic resonance images from 57 patients who recently recovered from first-episode mania (31 with a previous depressive episode and 26 without) and 57 healthy controls were acquired and processed using voxel-based morphometry. The processed gray matter tissue images were compared between depressed vs controls, non-depressed vs controls, and depressed vs non-depressed to ascertain gray matter alterations.

Results: Both depressed and non -depressed FE patients showed reductions in gray matter concentration (5%) in right and left medial frontal gyrus and anterior cingulate regions . Although reductions in gray matter concentration were also seen in insular region in both groups relative to controls, the reduction was only 0.05% in the non-depressed group while it was 4.1% to 5.2% in the depressed group.

Conclusion: In conclusion, FE patients with previous depressive episodes demonstrated more extensive gray matter reductions in the right ventral-orbital prefrontal cortex, bilateral ACC, and bilateral posterior insular cortex. This suggests, that either depressive episodes are associated with unique brain structural changes or previous depressive episodes lead to more extensive brain structural changes.

P3-09
MAJOR DEPRESSION RECURRENCE TRIGGERED BY CONTROL OF LONG-STANDING SEIZURE DISORDER AND TREATMENT OF DEPRESSION WITH ECT:

A CASE REPORT

Lead Author: Eugene Grudnikoff, M.D.

Co-Author(s): Dr. Priya Mahajan M.D.; Dr. Georgios Petrides M.D.; Dr. Sarjak Mehta M.D.

ABSTRACT:
Introduction: Depression and epilepsy have been shown to be interrelated and highly comorbid; various aspects of this correlation are poorly understood.

Methods: We report a case of a patient with long history of poorly controlled seizure disorder and remote history of depression. The patient experienced sudden recurrence of depressive disorder following successful treatment of the seizures. We describe successful treatment of depression using electroconvulsive therapy (ECT) and review current literature on the topic.

Case Description: The patient is a 57-year-old Caucasian female who presented with anhedonia, guilt, lack of energy, weight loss, and suicidal thoughts over a period of 8 months. Patient had been depressed as a teenager and young adult, but this was her first depressive episode since her 30's. At age 31 patient developed seizure disorder following multiple foot surgeries. The seizures persisted despite multiple mono- and combination treatments including valproic acid, carbamazepine, levetiracetam, lamotrigine, and vagal nerve stimulator trials. About a year prior to current presentation, patient was diagnosed with atrial fibrillation. Seizures resolved shortly after a cardiac pacemaker was implanted. Following a failed trial of sertraline for depression, patient was evaluated for ECT with coordination of cardiology and neurology services. Bifrontal electrode placement was used. During the first ECT treatment, the patient did not have a motor seizure from a stimulus set at 30 or 45 Joules; she had a 27 second EEG and motor seizure at 75 Joules. Three subsequent ECT treatments (3 times per week) were uneventful. Patient experienced an improvement in depressive symptoms and had a decrease in Hamilton Depression Rating Scale - 24 item (HAM-D) score from 32 prior to first treatment to 19 after the third treatment. She continues to receive maintenance ECT.

Conclusions: While epilepsy is recognized as a significant risk factor for depression, it is likely that physiological seizures had an anti-depressant effect in our patient. There were not case reports or controlled studies that observed this phenomenon.

P3-10
MEDICAL DETERIORATIONS AFTER ELECTROCONVULSIVE THERAPY IN A 1000-INPATIENT CONSECUTIVE COHORT

Lead Author: Eugene Grudnikoff, M.D.

Co-Author(s): Dr. Peter Manu M.D.

ABSTRACT:
Background: The risk of medical deteriorations after electroconvulsive therapy (ECT) has been assessed in uncontrolled evaluations of cohorts who had underwent the treatment, but has not been the focus of a controlled study in unselected psychiatric populations.

Objective: To compare the frequency and type of medical deteriorations of inpatients receiving ECT and of a control group of patients admitted for inpatient psychiatric care.

Methods: We conducted a structured review of 1000 consecutive inpatient admissions to a free-standing psychiatric hospital occurring between 2010 and 2011. Transfer to a general hospital emergency department (ED) from the psychiatric hospital was used as a proxy for significant medical deteriorations.

Results: Fifty-nine patients received ECT (336 total treatments, mean 5.7 treatments and range 1-20 treatments per patient). Eight ECT patients had 10 unique adverse events that required transfer to the ED (17.0%). Among patients who had a significant medical deterioration following ECT treatment (mean age 73 yrs, SD: 13 yrs), the most common reasons for ED transfer were fever (n=4), falls (n=3) and other neurological events (n=2). Medical deteriorations took place on average 4.7 +/-10.4 days after last ECT treatment (range: 0-37 d). One medical deterioration involved a non-sustained ventricular tachycardia occurring during ECT treatment. Of the 941 inpatients not treated with ECT, 134 (14.3%) had a medical deterioration, frequency similar to that of ECT patients (p=0.57). The frequency of medical deteriorations remained comparable between the groups when controlling for age greater than 65 years (p<0.36), the presence of coronary artery disease (p<0.73) and hypertension (p<0.32).

Conclusions: Frequency of significant medical deteriorations in a free-standing psychiatric hospital was comparable between inpatients receiving ECT and those receiving other treatments. Most adverse events were preventable and there was only one self-resolving serious cardiovascular event.

P3-11
KETAMINE FOR THE TREATMENT OF POSTPARTUM DEPRESSION

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Co-Author(s): Parekh, J DO; Eckmann, M M.D.; Quinones, M M.D.

ABSTRACT:
Introduction: Ketamine is an NMDA receptor antagonist frequently used as an anesthetic and analgesic. A growing body of research also indicates that Ketamine has rapid, robust and relatively sustained antidepressant effects. Here we report a case where Ketamine was successfully used to treat severe postpartum depression (PPD).

Methods: Psychiatry referred to our outpatient pain clinic for IV Ketamine treatment a 32 y/o female with a history of Major Depression who met DSM-IV-TR for a Major Depressive Episode with Postpartum Onset, Severe without Psychotic Features. Symptoms started 2 days after delivery. The patient's initial evaluation, 4 weeks postpartum, revealed prominent symptoms as indicated by a 7 item-Hamilton Rating Scale for Depression (HAMD7) score of 21/28; and an Edinburgh Postnatal Depression Scale (EPDS)= 26/30. Patient also reported fleeting SI, was unable to care for her baby and was considering not returning to her fulltime job. A prescribed antidepressant was ineffective and the patient discontinued it due to concerns about exposing her child medications through breast milk.

Results: Patient received IV Ketamine boluses of 25mg every 2-5 minutes up to a total of 200mg with continuous vital sign monitoring. The treatment was well tolerated. The patient discarded breast milk collected 24h after the infusion to avoid exposing her baby to Ketamine. The patient's depressive symptoms improved immediately post-infusion, reaching complete remission by day 7 (HAMD7=2 and EPDS=2) with no SI. Patient returned to her full time job, remaining in remission for 4.5 weeks post-infusion without any other antidepressant treatment. But in the context of social stressors she had a relapse of her PPD. However a second IV Ketamine treatment conducted as described above resulted in remission of symptoms from day 7 until now.

Conclusion: The outcome of this case is encouraging. Further studies are needed to conclusively demonstrate the efficacy Ketamine in the treatment of PDD.

P3-12
RUMINATIVE RESPONSE STYLES AND METACOGNITION IN INTERNET ADDICTS

Lead Author: Oya Guclu

Co-Author(s): Omer Senormanci; Ramazan Konkan; Oya Guclu; Guliz Senormanci

ABSTRACT:
Introduction: According to the cognitive behavioral model, maladaptive cognitions about the self and the world may lead to Internet addiction (Davis, 2001). And, maladaptive cognitions have a key role in Internet addiction regardless of the culture (Mai et al., 2012). Caplan modified the cognitive behavioral model of Internet addiction, suggesting 4 main components, which include Preference for Online Social Interaction, Mood Regulation by Internet, Deficient Self-regulation and Negative Outcomes (Caplan, 2010).

Spada et al. investigated metacognitions as a mediator of the relationship between PIU and negative feelings (distress, depression, anxiety) in university students using the Internet. As a result, they found that there was a positive relationship between problematic Internet use and five dimensions of the Metacognitions Questionnaire-MCQ, including 'positive beliefs', 'cognitive confidence', 'uncontrollability and danger', 'cognitive awareness' and 'need of control' and negative feelings. These results support the assumption that the relationship between Internet addiction and negative feelings are totally mediated by metacognitions (Spada et al., 2008).

Response styles theory focuses on style or processing rather than content of thoughts in response to stressors (Nolen-Hoeksema & Morrow, 1991). Davis proposed that Internet addicts have repetitive thoughts about the causes and consequences of their Internet usage rather than focusing other events in their life, which, in turn, maintain or exacerbate their Internet addiction (Davis, 2001).

Aim: Although cognitive behavioral model of Internet addiction has been well described, studies on metacognitions and ruminative response styles related with Internet addiction are very limited. The aim of the present study was to compare metacognitions and ruminative response style in Internet addicts with a healthy control group.

Method: The study included 30 males who presented to our Internet Addiction Polyclinic, and diagnosed with Internet addiction, and a control of group of 30 healthy males with similar sociodemographic characteristics. A sociodemographic data form, Internet Addiction Test (IAT), Metacognitions Questionnaire (MCQ-30), Ruminative Response Scale-short version (RRS-SV), and Beck Depression Inventory (BDI) were used for data collection.

Results: The mean age for the study group was 26.5±9 years vs. 24.3±6 years for the control group. The daily duration of Internet use was 9.6±2.3 hours in the study group while it was 2.9±1.3 hours in the control group. The BDI score for the study group was 18.9±13 vs. 6.7±5.6 in the control group. The IAT score was 49.2±13.8 in the study group, and 24.5±4.7 in the control group. The MCQ-30 and RRS-SV scores were higher in the study group for total and subscales. An intergroup comparison using Student's t-test showed a statistically significant difference between the MCQ-30 total (p=0.012), MCQ-30 uncontrollability and danger score (p=0.032), MC

P3-13
OBSESSIVE BELIEFS IN MAJOR DEPRESSION

Lead Author: Oya Guclu

Co-Author(s): Mazan Konkan,Ömer Senormanci,Oya Guclu,Erkan Aydin,Murat Erkiran

ABSTRACT:
Introduction: Beck et al. indicated that dysfunctional thoughts and schemes may render an individual prone to depression (Beck et al., 1979). It has been reported that dysfunctional thoughts and attitudes prior to therapy may also be predictive of treatment outcome in depression (Dobson & Breiter, 1983; Shankman et al., 2003). Levels of dysfunctional thoughts are found to be higher in depressive patients than in non-depressive subjects, and also higher in patients with chronic depression than in subjects with no chronic depression (Ley et al., 2011). Several studies show that higher levels of dysfunctional beliefs may be an indication of a poor response to pharmacotherapy and psychotherapy (Pedrelli et al., 2008; Peselow et al., 1990). NIMH collaborative depression study reported that lower levels of dysfunctional attitudes may be a predictor of a positive response to cognitive behavioral therapy (CBT) (Sotsky et al., 1991).

There has been an increase in the number of studies on identification of dysfunctional thoughts and beliefs after significance of dysfunctional thoughts and schemes in development and maintenance of psychiatric disorders has been demonstrated. The Obsessive Compulsive Cognitions Working Group reported that three different belief domains including Perfectionism/Certainty, Responsibility/Threat Estimation, Importance/Control of Thoughts are important in development and maintenance of Obsessive Compulsive Disorder (OCD) based on a factor analysis (Obsessive Compulsive Cognitions Working Group, 2005). There is an ongoing debate on specificity of these beliefs to OCD. It has been suggested that obsessive beliefs can be common mediators not only in the development of OCD, but also of many anxiety and emotional disorders (Tolin et al., 2006; Konkan et al., 2012).

Although it has been reported that significance of differences changes after controlling for confounding effect of depression and anxiety levels while comparing obsessive beliefs in several anxiety disorders, we haven't seen any study which evaluated obssessive beliefs in depressive patients in the literature. Identification of obsessive beliefs in depressive patients may be beneficial for determination of novel cognitive behavioral interventions. The aim of this study was to identify obsessive beliefs in depressive patients and make a comparison with healthy volunteers.

Method: The study included 106 patients who presented to the Bakirkoy Research and Training Hospital for Psychiatry, Neurology and Neurosurgery out-patient clinic and diagnosed with depression according to the DSM-IV-TR criteria and a control group of 98 healthy volunteers with similar sociodemographic characteristics. The Obsessive Beliefs Questionnaire-44 (OBQ-44), State-Trait Anxiety Inventory (STAI), and Beck Depression Inventory (BDI) were used for data collection.

Results: In the depression group, the depression score was 27.4±11.6; the STAI state score was 49.6±10.7; and the STAI trait score.

P3-13
A PROSPECTIVE NATURALISTIC STUDY OF ANTIDEPRESSANT-INDUCED ANXIETY SYNDROME

Lead Author: Tsuyoto Harada, M.D., Ph.D.

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ABSTRACT:
Objective: Patients often develop neuropsychiatric symptoms such as anxiety, agitation and so on after they start taking an antidepressant, which is thought to carry a potentially increased risk of suicide. However, the incidence of antidepressant-induced anxiety syndrome has not been fully investigated and little has been reported on its predictors. The aim of this study was to survey the incidence of antidepressant-induced anxiety syndrome and clarify its predictors in a natural clinical setting.

Method: We prospectively surveyed the cases of 301 patients between January 2009 and July 2012 who did not take any antidepressants for one month before visiting and were prescribed antidepressant during one month after initial visit. Patients were classified as developing antidepressant-induced anxiety syndrome if they experienced any symptom of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia, hypomania and mania during the first one month.

Results: Of the 301 patients, 21 (7.0%) developed antidepressant-induced anxiety syndrome. First-degree relatives of persons with mood disorder and DSM-IV-TR diagnosis of major depressive disorder were significantly associated with the induction of antidepressant-induced anxiety syndrome (Odds Ratio=10.2, p=0.001 and Odds Ratio=4.65, p=0.02, respectively). The incidence was not significantly related to gender, age, class of antidepressant, combined use of benzodiazepine, or DSM-IV-TR diagnosis of anxiety disorder.

Conclusions: This study suggests that first-degree relatives of persons with mood disorder and DSM-IV-TR diagnosis of major depressive disorder may be a clinical predictor of antidepressant-induced anxiety syndrome, which might suggest those who develop antidepressant-induced anxiety syndrome have potentially tendency for bipolar disorder.

P3-15
A CRITICAL REVIEW OF THE FINDINGS IN STUDIES COMPARING GENDER RELATED FACTORS IN BODY DYSMORPHIC DISORDER

Lead Author: Rupal Patel MRCPsych, M.B.B.S.

Co-Author(s): Dr Rupal Patel; Dr Pratima Singh; Dr Lynne M Drummond

ABSTRACT:
Gender is integral to the cognitive construct of the body image of self and others. It is therefore imperative that there would be gender specific differences in any disorder of body image. Body Dysmorphic Disorder (BDD), which is characterised by an excessive preoccupation with an imaginary or trivial bodily attribute causing disproportional distress, is an example of one such body image disorder. We did a literature review of gender specific differences in BDD for the purpose of identifying unique factors which can be used to improve the efficacy of cognitive behavioural treatment for this illness.

A literature search was performed on pubmed, web of knowledge, conference abstracts and individual journals in this area. The following search terms from MeSH database were used to identify the relevant research articles: [included in final poster]. Translations were obtained for articles which were in languages other than English. A manual review of the references quoted in identified studies was done to identify any additional studies. Studies which fit the following criteria were included in the final list:

1.The primary aim of the study is to compare gender specific differences in BDD.

2.The sample population consisted of patients with a primary diagnosis of BDD.

3.The diagnosis of BDD was made in a clinical setting by a mental health clinician by using either DSM or ICD criteria following a clinical interview.

4.The study used standardised diagnostic criteria for diagnosing BDD.

5.The gender specific data (both significant and insignificant findings) were made available in the published text.

In the final shortlist of seven studies, the following studies were excluded as they did not meet the criteria specified above: Marques et al 2011, Taqui et al 2008, Woodie et al 2009. Following four studies as meet our criteria for inclusion in the final analysis, giving us a pooled sample size of 500 (286 Females & 214 Males).

1.Philips, K. et al 1997 – USA, Sample size: 188 (93 Females & 95 Males)

2.Perugi et al 1997 – Italy, Sample size: 58 (24 Females & 34 Males)

3.Philips, K. et al 2007 – USA, Sample size: 200(137 Females & 63 Males)

4.Tyagi 2011 – UK, Sample size: 54 (32 Females & 22 Males)

Our analysis of 500 patients reiterated the findings reported by all earlier studies that there are more similarities than differences between males and females. Some gender differences which were found to be significant were consistent with the findings of the individual studies. There were fewer differences in terms of preoccupation with body parts, but comparatively larger differences in terms of social and demographic factors between the two genders. Men were more likely to be preoccupied with their genital organs and females were more likely to be involved in camouflaging behaviour (which was grouped together as one variable for the purpose of this analysis). No difference in clinical risk posed by this illness was noted between the two genders.

P3-16
PERNICIOUS DEPRESSION

Lead Author: Jill Joyce, M.D.

ABSTRACT:
What is undisputed is that Vitamin B12 is essential for brain health. What is unclear is how much of a role B12 or its lack plays in depression and other psychiatric disorders, how best to test for and diagnose B12 deficiency, and the prevalence of B12 deficiency. For many years the acceptable levels of B12 in the body have been 200-1100 pg/ml. More recent work, including the addendums from Quest Laboratories, and Pocholok & Stuart, suggest the range needs to be 400-1100 pg/ml. An epidemiological study of Vitamin B12 levels in a typical suburban psychiatric practice was undertaken. The patient age range was 21-95 yo. The diagnoses ranged from anxiety to depression to psychosis and bipolar disorder. Three tests were performed- B12, Folic acid, and Methylmalonic Acid(MMA). A total of 207 patients were tested. Of these, all had normal folic acid levels. 68 of 198 or 0.3434% had low B12, with B12 under 400 pg/ml. 3 were under 200, 26 under 300. 12 of 173 had abnormally high MMA levels, ranging from 352-864, with 8 over 400. All identified as low B12 or High MMA were given B12 injections weekly or every two weeks. Results were anecdotally positive. B12 deficiency is possibly under appreciated as a cause for psychiatric illness.

P3-17
HOW IMPORTANT IS VITAMIN D IN DEPRESSION?

LOW VITAMIN D LEVELS IN A SUBURBAN PRIVATE PSYCHIATRIC PRACTICE

Lead Author: Jill Joyce, M.D.

ABSTRACT:
It has become apparent that Vitamin D levels in much of the population have dropped. This is an attempt to evaluate Vitamin D levels in a suburban private psychiatric practice. The role of Vitamin D in depression may be larger than presently thought.

All patients in a suburban private psychiatric practice were asked to obtain serum Vitamin D levels. The age range was from 21-95 years old. The diagnoses ranged from Anxiety to Depression to Bipolar Disorder, Psychosis and substance abuse issues. A total of 194 patients were tested. Of these, 100 patients, or 51%, had Vitamin D levels below 30 ng/ml. 43 patients, or 22%, had Vitamin D levels under 20 ng/ml, several under 10 ng/ml. Adequate levels are felt to be 30-90 ng/ml, with the Vitamin D Council recommending patients test in the 40-60 ng/ml range.

A large number, over half, of patients were found to be Vitamin D deficient. It is becoming more apparent that Vitamin D needs to be more fully assessed and studied in the psychiatric population.

P3-18
A CONTROLLED PILOT STUDY EXAMINING PROBLEM-SOLVING THERAPY IN SUBSYNDROMALLY DEPRESSED VETERANS

Lead Author: John Kasckow, M.D.

Co-Author(s): J Klaus, G Haas, J Morse, S Yang, L Fox, J Luther, C Reynolds, D Oslin

ABSTRACT:
Background: Subsyndromal depressive disorders are common in middle aged and older veterans in primary care settings. These individuals are at high risk for developing major depression. Problem Solving Therapy (PST) is an evidenced-based treatment which helps individuals with depression and other disorders. We conducted a pilot study comparing PST-Primary Care to a dietary education control condition in veterans with symptoms of emotional distress and subsyndromal depression. We hypothesized that depressive symptoms and social problem solving skills would improve with PST-Primary Care.

Methods: This was a 2-site study at the VA Pittsburgh Healthcare System and Philadelphia VA Medical Center. Participants included veterans > 49 years of age referred from primary care clinics who were eligible if they obtained a pre-screen score of >10 on the Centers for Epidemiologic Studies - Depression scale. Exclusions were DSM IV Major Depressive Episode within the past year, active substance abuse/ dependence within 1 month, current antidepressant therapy and a Mini Mental Status (MMSE) score < 24. We assessed depressive symptoms with the 17 item Hamilton Depression Rating Scale (HRS 17) and the Beck Depression Inventory (BDI). We assessed problem solving skills with the Social Problem Solving Inventory (SPSI). Participants were randomized to receive 1 of 2 interventions, each consisting of 6-8 sessions within a 4 month period of PST-Primary Care or an attention control consisting of dietary education (DIET).

Results: Of 25 patients who received either intervention, 12 received PST-Primary Care and 13 received DIET. The mean (+/- standard deviation) age was 61.9 +/- 9.8 years; 43% were African American and 57% were Caucasian. The average education was 13.4 +/- 2.4 years. Baseline clinical characteristics were: MMSE scores: 27.5 +/- 1.8 years; BDI scores: 11.4 +/- 5.3 years; HRS17 scores: 11.4 +/- 4.5; SPSI scores: 99.3 +/- 13.6. There were no significant differences in either PST-Primary Care or DIET group in baseline demographic or clinical scores. At the end of treatment, there were significant differences in BDI scores between treatment groups; endpoint scores were: 3.6 +/- 4.7 (PST-Primary Care) vs 9.0 +/- 4.3 (DIET), p = 0.019 based on ANCOVA. At the end of treatment there were also significant differences in SPSI scores for the PST-Primary Care group{(107 +/- 13.9) vs the DIET group (101 +/- 6.9)} based on ANCOVA, p = 0.049. No significant endpoint differences were noted in HRS17 scores.

Conclusions: These preliminary pilot study findings suggest that a 6-8 session of the Primary Care version of Problem Solving Therapy may lead to improvements in self reported depressive symptoms in primary care veterans with subsyndromal depressive symptoms. In addition, PST is associated with improvements in social problem solving skills.

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P3-19
SYMPTOM SEVERITY AND FUNCTIONING IN PRIMARY CARE VETERANS WITH SUBTHRESHOLD POSTTRAUMATIC STRESS DISORDER

Lead Author: John Kasckow, M.D.

Co-Author(s): Derik Yeager, Kathryn Magruder

ABSTRACT:
Background: There are no agreed upon criteria for making a determination of subthreshold Post Traumatic Stress Disorder (PTSD). We examined the 4 definitions of this syndrome and compared them in their ability to distinguish primary care patients with respect to PTSD symptom severity and levels of functioning meeting either of the 4 subthreshold criteria, those meeting criteria for PTSD and those not meeting criteria for either.

Methods: The dataset came from a regional sample of 815 primary care veterans at 4 VAMC's who had been assessed with the Clinician Administered PTSD Scale (CAPS) and were also administered the PTSD Checklist (PCL) and SF-36. We used simple point biserial correlations to compare SF 36 mental health and physical health component scores between patients meeting criteria for one of the 4 definitions of subthreshold PTSD (i.e., based on Blanchard, Marshall, Stein and Schurr) relative to those with CAPS (+) PTSD vs those not meeting criteria for subthreshold or syndromal PTSD. The same comparisons were made with respect to Post Traumatic Stress Disorder Checklist (PCL) scores.

Results: The prevalence of subthreshold PTSD ranged from 4.0% to 9.7%; the Marshall definition yielding the greatest number of cases. All 4 case definitions were able to discriminate differences in overall PCL scores as well as SF 36 mental health component scores. However, the Blanchard and Marshall definitions were not able to discriminate SF 36 physical health component scores from individuals who had PTSD

Conclusions: It appears that each of the 4 definitions appear to be equivalent in demonstrating differences in mental health functioning and overall PTSD severity in primary care veterans relative to those with PTSD or no PTSD and not meeting criteria for a subthreshold criteria. The Schnurr and Stein definitions appear to be more optimal in discriminating individuals with respect to physical health functioning.

P3-20
COGNITION, FUNCTIONAL CAPACITY, AND EVERYDAY DISABILITY IN WOMEN WITH PTSD

Lead Author: Joanna Kaye, B.A.

Co-Author(s): Solara Calderon, BA; Caitlin Ridgewell, BA; Boadie Dunlop, M.D., MS; Dan Iosifescu, M.D., MMSc; Sanjay Mathew, M.D.; Philip Harvey, PhD

ABSTRACT:
Background: It has been increasingly understood that individuals with PTSD experience cognitive impairments in addition to their primary clinical symptoms as well as disability that is disproportionate to their symptom severity. In other neuropsychiatric conditions, impairments in cognition and functional capacity, the ability to perform critical everyday living skills, are associated with impairments in everyday functioning. This is the first study to report on impairments in functional capacity and their association with cognitive deficits and real-world functioning in PTSD.

Methods: 74 female patients with PTSD were examined at baseline in a randomized double-blind treatment trial. These patients self reported their depression with the MADRS and their disability with the Sheehan Disability Scale (SDS), were assessed with a well-normed cognitive assessment battery (the MATRICS Consensus Cognitive Battery: MCCB), performed an assessment of functional capacity (the UCSD Performance-Based Skills Assessment: UPSA), and were rated by the interviewer on their PTSD severity.

Results: Patients with PTSD manifested mild-to moderate impairments on the UPSA, performing a full standard deviation below healthy norms. They were moderately depressed (MADRS Mean=27) and their neuropsychological (NP) test performance was impaired to an extent generally similar to their UPSA performance (MCCB Mean t-score=44.11). NP performance was correlated with UPSA scores as seen in previous studies of other neuropsychiatric conditions. However, although MADRS and CAPS were correlated with each other and with self-reported disability, there was no correlation between self-reported disability and either NP or UPSA performance.

Implications: In other neuropsychiatric conditions, self-reported everyday functioning is often not strongly associated with performance on NP tests or measures of functional capacity. However, objective information on disability and clinician reports of functioning are often much more strongly correlated with performance-based assessments. These data suggest the need to examine the relationship between self-reported disability and objective information about real-world functioning in PTSD and to determine whether impaired cognition is associated with real-world disability in this condition.

P3-21
PATIENT SATISFACTION IN AN URBAN HOSPITAL INPATIENT PSYCHIATRIC UNIT

Lead Author: Uchenna Madubuko, M.D. MPH

Co-Author(s): Samina Mirza, M.D., Uchenna Madubuko, M.D., Preveena Machineni, M.D., Ritesh Amin, M.D., Margoraza Komza, M.D.

ABSTRACT:
Inpatient Psychiatric services are part of the Key Quality Measures of the Joint Commission for Accreditation of Health Care Organizations (JCAHO). These services present numerous challenges in academic medical centers, especially in general hospitals. There is pressure to reduce lengths of stay; involuntarily committed patients may stay longer and have a more difficult hospital course. Our inner-city tertiary care academic medical center has 34 inpatient beds with both voluntary and involuntary patients. Many of

these patients have complicated medical conditions (diabetes, HIV/AIDS, Hepatitis, substance use disorders), and most are poor. We are interested in knowing what factors correlate with patient satisfaction.

Methods: In this study we examined Patient Satisfaction as part of our quality assessment and improvement program. We interviewed patients regarding their level of satisfaction with the hospital stay and whether they would recommend the hospital to others. The face-to-face interview was conducted on discharge day (fully developed discharge plan), We used a survey adapted from the Massachusetts General Hospital. Data was abstracted from the medical record (demographic, diagnostic, medical information). Spearman's correlations of continuous and ordinal variables were done. To explore group differences in PSS-8, Mann-Whitney test or in greater than 2 independent groups Kruskal-Wallis test was used. Post hoc test was done using Bonferroni correction. Logistic regression was performed to determine predictors. The following independent variables were examined age, gender, race, disposition, use of typical/atypical antipsychotics, LOS, GAF at admission, legal status, domicile, toxicology and drug reports. IBM SPSS version 21 was used for the analysis.

Results: 152 patients consented; 52.6% were males. 47.4% females. The mean age at discharge was 39.4 (SD=13.8, range 18-81, N=150), the mean GAF at admission was 28.9 (SD12.4, range 0-60). Mean LOS was 9.4 (SD6.9 range 2-39). The median PSS at discharge 34.5 (range 11-38).63.8% were African Americans; 25.7% Whites.15.8% (24) were homeless. 36.8% had positive toxicology report while 59.2% admitted use of substances. 20.4 % had schizophrenia; 19.7% bipolar d/o; 17.8%; MDD, 15.8% were schizoaffective. 34.2% (52) were treated with atypical antipsychotics; 21% typical while 4.6% received both. Patient satisfaction was high throughout and correlated with age: older the patient, the more satisfied they were with inpatient care. Males are more likely to recommend psychiatric facility and males were 9.5 times more likely to recommend the hospital facility when compared to females (p=0.012). Involuntary patients were less likely to recommend the hospital.

Discussion: Patient satisfaction and recommendation are not correlated with diagnosis or types of treatment, but rather with age. Further analysis of patient's narrative comments will be done to determine what else is in satisfaction.

P3-22
ANTIDEPRESSANTS WILL NOT KEEP YOU OUT OF THE HOSPITAL: A ONE-YEAR FOLLOW UP OF 377 PATIENTS WITH BIPOLAR DEPRESSION

Lead Author: Kalya Vardi, M.D.

Co-Author(s): Kalya Vardi, M.D.; Noah Philip, M.D.

ABSTRACT:
Introduction: Depressive episodes remain the major cause of disability in bipolar patients. Recently, research from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) indicated that adding an antidepressant to a mood stabilizer confers no additional benefit over a mood stabilizer alone. We have observed that, despite these data, antidepressants are often prescribed for bipolar depression in our hospital and hypothesized that their ongoing use might reflect a clinical advantage not observed in research trials. The purpose of this study was to evaluate this potential effect using all-cause hospital readmission rates as a naturalistic metric of psychiatric outcomes in the year post-discharge.

Methods: A retrospective chart review was conducted on patients ages 18-65 with Bipolar I Disorder, Most Recent Episode Depressed, who were discharged from Butler Hospital in Providence, RI, from January 1, 2008 to July 12, 2011. Participants were divided into those that were prescribed an antidepressant at discharge (AD+) and those that were not (AD-). Only those on an adequate dose of a mood stabilizer or atypical antipsychotic were included. Primary outcome measures were the impact of antidepressant exposure on readmission rates and time to readmission in the year post-discharge. Secondary analyses examined the impact of individual antidepressants, anxiety and affective switch rates.

Results: 377 patients were included in the study. There were no clinically significant demographic differences between AD+ and AD- groups. Binary logistic regression showed no group differences in readmission rates in the year post-discharge (p = .77). Survival analysis using Cox regression showed no group differences in time to readmission in the year post-discharge (p = .88); mean time to readmission was 205 ± 152 days. Those with anxiety disorders had a significantly higher readmission rate and shorter time to readmission regardless of antidepressant status. When controlling for anxiety , patients discharged on venlafaxine were more likely to be readmitted compared to the AD- group or those on other antidepressants (hazard ratio=2.35, 95% CI 1.03-5.38) with a statistical trend for patients on venlafaxine to be readmitted more rapidly. There was no relationship between antidepressant class and affective switch; however, anxiety was a strong predictor of affective switch (hazard ratio=7.61, 95% CI 2.27-25.52).

Conclusions: Our findings are consistent with and expand upon STEP-BD using a clinically relevant outcome measure. Our study suggests that antidepressants do not prevent hospital readmission and that venlafaxine may be harmful. It also demonstrates that bipolar depression with comorbid anxiety represents a significant clinical problem. While our data are limited by their retrospective nature, these results should prompt clinicians to carefully consider antidepressant use for bipolar depression.

P3-23
PRELIMINARY RESULTS OF DEPRESSION TREATMENT IN BIPOLAR II DISORDER USING CRANIAL ELECTRICAL STIMULATION (CES)

Lead Author: Siva Koppolu, M.D.

Co-Author(s): G Kazariants, M Varvara, D McClure, Z Yaseen, AMR Lee, I Galynker

ABSTRACT:
Introduction: Cranial Electrical Stimulation (CES) is a non-invasive brain stimulation technology which has been FDA cleared for the treatment of depression, anxiety and insomnia. However, there is a relative lack of controlled clinical trials supporting its efficacy in treating the depressive phase of bipolar II disorder. This single blind, randomized, sham controlled study examines the safety and efficacy in this particular group of patients. Preliminary results of the study are discussed.

Methods: Patients diagnosed with bipolar II disorder currently experiencing depression symptoms by SCID-P were recruited from the Family Center for Bipolar in New York City. Subjects were randomly assigned to two groups in phase I: a placebo group and an active group, for the first two weeks of daily 20 minute treatment sessions. Following this both groups received an active treatment for additional two weeks in phase II. Depression symptoms were rated using the Hamilton Depression Rating Scale (HAM-D), the Beck Depression Inventory (BDI) and the quality of life was assessed using the Quality of Life Satisfaction and Enjoyment Questionnaire (Q-LES-Q). The assessments were completed at the study intake, at the end of the 2nd week of treatment (placebo group) and 4th week of treatment (experimental and placebo groups) during the treatment period.

Results: Patients were 75% male and 50% white, with a mean age of 52.00. The treatment group had a 38% decrease on the HAM-D mean score (baseline M=22.00, 4th week M=13.67), also a 30% decrease on the BDI (baseline M=41.00, 4th week M=27.67) and a 31% increase on the Q-LES-Q (baseline M=28.67, 4th week M=37.67) The placebo group had no change on the HAM-D (baseline and the 2nd week M=20.00), a 22% decrease on the BDI (baseline M=38.00, the 2nd week M=30.00.) After additional two weeks of active treatment the placebo group had an average of 40% decrease on the HAM-D (M=12.00), a 39% decrease on the BDI score (M=23.00) and a 69% increase on the Q-LES-Q (M=54.00) compared with the baseline scores.

Discussion: CES therapy had a positive treatment effect reducing the level of depression in the experimental group from severe to mild and was associated with an increase in quality of life during the treatment period. In the placebo group the depression level did not change on the clinician administered scale but was reduced on the self-report scale. After additional two weeks of active treatment the placebo group also had a reduction in depression symptoms levels and an increase in life satisfaction.

Key Words: Bipolar Disorder, Depression, Cranial Electrical Stimulation

P3-24
HEALTH PROMOTION AND RISK BEHAVIORS IN BIPOLAR PATIENTS: PERCEPTION OF EFFECTS ON BIPOLAR ILLNESS

Lead Author: Anna Kreiter, B.A.

Co-Author(s): Patrick Chang Hou M.D., Nancy C. Maruyama M.D.

ABSTRACT:
Introduction: Bipolar disorder (BD) patients have high rates of medical illness that may be modifiable by health behaviors. Little is known about health screening and promotion behaviors (exercise, diet, etc.) in individuals with BD. High functioning BP patients report using behaviors that ameliorate medical illness (exercise, diet) to manage bipolar illness. We examine health behaviors patients with severe illness.

Methods: 32 participants, aged 44.8 years (12.4) completed self-report measures identifying medical screening behaviors (physical exam, cholesterol screening, etc.), health promotion behaviors, and their perception of these behaviors on mood and course of bipolar illness.

Results: 71.9% reported 5 to >20 depressive episodes, 59.5% with 5 to >20 manic episodes. In the past year 77% had a physical exam and 65.6% had cholesterol screening. Since diagnosis, 100% of smokers had tried to quit. 87.5% (n = 28) tried to sleep regularly and relax, 81.3% (n = 26) to improve diet, 75% (n= 24) to exercise more, and 65.6% (n = 21) to lose weight. 90.6% felt some changes could influence mood, and 71.9% felt they could influence the course of illness.

Conclusions: A large percentage of our sample report medical screening behaviors. Severely ill patients use similar health behaviors to manage BP illness compared with high functioning patients. In addition to diet and exercise, behaviors such as sleep, relaxation and socializing were reported to potentially influence mood and course of BP illness. Patients' perceptions of the psychiatric effects of health

behaviors can inform interventions to motivate behavior change.

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P3-25
MOOD DISORDERS IN OPIOID ABUSERS UNDER CRIMINAL JUSTICE SUPERVISION

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ABSTRACT:
Introduction: Individuals with mood disorders are common in correctional settings. Depression and bipolar disorder have been associated with high rates of recidivism . Moreover, these conditions are often comorbid with substance abuse, and increase the likelihood of high-risk sexual and drug use behavior, which may lead to infection with HIV . We examined the prevalence of mood disorders as part of the National Institute on Drug Abuse's (NIDA) Seek, Test, Treat, and Retain initiative to test the effectiveness of Buprenorphine treatment among HIV-positive, opioid-dependent individuals who are under pretrial or probation supervision in Washington, DC.

Method: At the screening interview, participants completed the Patient Health Questionnaire-9 (PHQ-9) (a widely used screening instrument for depression), the Addition Severity Index, Lite version (ASI-lite) (used to assess family history of alcohol, drug, and psychiatric problems), and the Mood Disorder Questionnaire (MDQ) (used to screen for bipolar disorder).

Results: All volunteers were opioid-dependent African Americans (N=135), with a mean age of 50. More than 90% of the sample screened positive for at least mild depression, and 23% showed a positive screen on the MDQ. Both moderately/severely depressed individuals and those who screened positive for bipolar disorder had significantly more legal issues, as shown by composite scores on the ASI (t=-2.02, p?.05; t=-2.36, p<.05), psychiatric (t=-5.37; p=.000; t=-3.19, p<.01), and medical status (t=3.78, p<.05; t=-2.76, p<.01) areas. In addition, 46% of the sample indicated that they had been previously diagnosed with bipolar disorder.

Discussion: These findings are consistent with others of the substance abusing correctional population in showing high rates of mood disorder. The results are striking, however, in the high rates of bipolar disorder. The MDQ is notorious for false positives , and a confirmatory assessment must be done. The rate of individuals indicating that they had ever been diagnosed with bipolar disorder is even higher than the rate with an MDQ+ score, which stands in stark contrast with the under recognition of mood disorders often seen in African Americans.

P3-26
CONTEXT IS IMPORTANT: EMOTIONAL MALTREATMENT AND TRAITS RELATED TO DAMAGED SELF CONCEPT IN CHILDHOOD MEDIATE CLUSTER B PERSONALITY PATHOLOGY IN ADULTS

Lead Author: Olga Leibu, M.D.

Co-Author(s): Ethan Lu; Dilini Herath; Azra Qizilbash; Thachell Tanis; Dr. Lisa Cohen, PhD

ABSTRACT:
Introduction: Despite a multitude of research demonstrating an association between child abuse and personality disorders, understanding of this relationship remains crude. To elucidate the mechanisms underlying this relationship, we asked whether self- related personality dimensions (Stable Self-Image, Self Reflexive Functioning, Self-Respect, Feeling Recognized) mediate the relationship between childhood trauma and cluster B pathology.

Methods: One hundred and thirteen patients were recruited from three inpatient units and the outpatient service in a large urban hospital. The following measures were used. The Childhood Trauma Questionnaire is a 28 item, self- report questionnaire measuring sexual, physical and emotional abuse as well as physical and emotional neglect. The SIPP-118 is a 118-item, self-report questionnaire that yields 16 personality facet scores grouped into 5 higher order domains: self-control, identity integration, relational capacities, social concordance, and responsibility. The Personality Diagnostic Questionnaire (PDQ-4+) is a 99-item, True/False questionnaire designed to assess for the ten DSM-IV-TR personality disorders plus two provisional personality disorders. The PDQ-4+ yields a total score as well as subscales for each of the DSM-IV axis II personality disorders. The following scales were used for analysis: borderline, antisocial, narcissistic.

Stepwise hierarchical regression analyses and structural equation modeling (SEM) were performed to assess the direct and mediated effects of emotional abuse on all three cluster B disorders.

Results: In three separate regression analyses, emotional abuse was significantly associated with each of three cluster B disorders, yielding betas of .363, .235, and .384 for antisocial, narcissistic, and borderline, respectively. When the four self-related personality traits were added to each of the models in the second step, the R2 change was significant for all three models. In other words, emotional abuse on its own was less strongly associated with each of the Cluster B disorders than when combined with the four self-related traits. By SEM, the aggregate of the four self-related personality traits had a statistically significant mediating effect (43, 49, and 75%, of the total effect) on the relationship between self-reported childhood emotional abuse and antisocial, borderline, and narcissistic traits, respectively.

Conclusion: The current study provides support for the hypothesis that a) there is an effect of childhood emotional abuse on Cluster B personality pathology in adulthood and b) this effect is mediated by personality traits related to a damaged self-concept. The mediating effect is strongest for narcissistic personality traits but also substantial for antisocial and borderline personality disorder traits.

P3-27
LONG-TERM USE OF SECOND GENERATION ANTIPSYCHOTICS [SGAS] IN TREATMENT OF UNIPOLAR DEPRESSION: A SAFETY CONCERN

Lead Author: Tushar J. Makadia, M.B.B.S.

ABSTRACT:
Objective: SGAs use has expanded from treatment of schizophrenia to bipolar mania and unipolar and bipolar depression. It is important to consider estimating long term risk and benefits of continuing of such treatment while treating unipolar depression.

Case Presentation: 64 Year old widowed domiciled Ethiopian male, employed as an accountant with previous psychiatric history of Major Depression [No history of previous psychiatric hospitalization], anxiety disorder presents with complains of burning stomach pain (despite negative medical work up and current treatment with Nexium), and excessive worries related to work up on initial presentation. He also complains of anhedonia, poor appetite, inability to concentrate at work, insomnia. He currently takes Olanzapine [for approximately 9 years] and Dextroamphetamine as prescribed by previous psychiatrist after unsuccessful trials of Fluoxetine (worsening of stomach pain), Quetiapine and Modafinil. Patient presents with Tardive dyskinesia (TDs) of moderate severity of lip, tongue and perioral area for around 3 years and is progressively worsening. Patient was gradually tapered off Olanzapine and Dextroamphetamine while concurrently started on Mirtazepine. Symptoms significantly improved on CUDOS [Clinically useful depression outcome scale] from score of 35 to 19 over 4 week's period.

Discussion: SGAs have been proven efficacious in treatment of unipolar depression in combination with SSRIs. SGAs are prescribed for treatment of affective disorders including depression with or without psychotic features. Such treatment is associated with tolerability issues such as metabolic adverse effects (weight gain, increase in blood glucose, total cholesterol and triglyceride levels) and extra pyramidal symptoms [EPS] [i.e. Parkinsonism, akathisia, tardive dyskinesia) and have effect on mortality and morbidity. Currently there are no clear guidelines for use of SGAs for treatment of depression. Also it is unclear how long should one continue antipsychotic after remissions is achieved? What is long term risk of TDs and other morbidities associated with continued treatment of SGAs? More studies need to be conducted in order to stratify the safety of long term of use of SGAs in treatment of depression.

P3-28
PREVALENCE OF ANXIETY AND DEPRESSION IN PATIENTS WITH SLEEP DISTURBANCE

Lead Author: Abid Malik, M.D.

ABSTRACT:
According to the National Institute of Mental Health, about 14.8 million US adults currently suffer from major depression 1. It is estimated that by the year 2020, major depression will be second only to ischemic heart disease in terms of the leading causes of disability worldwide 2. Sleep disturbance and psychiatric disorders are quite interrelated, and one affects the other. We study the prevalence of anxiety and depression in patients presenting to the Sleep Disorder Center of our hospital with the complaint of sleep disturbance from Oct 2011 till Sept 2012. This is the first step in the process, with the hope to increase awareness for the screening of anxiety and depression in this population, so that appropriate referrals can be given to these patients. Our

next step would be to attempt to study the effect of sleep disorder treatment on depression and anxiety.

P3-29
THE IMPACT OF ECONOMIC DOWNTURN ON DEPRESSION IN THE U.S. POPULATION

Lead Author: Kaushal Mehta, M.B.B.S., M.D.

Co-Author(s): Murali Rao, M.D.; Holly Krammer, M.D. MPH; Ramon Durazo, PhD; Guichan Cao, MS

ABSTRACT:
Background: By 2020, depression is expected to be second leading cause of disability in the U.S. population. The economic downturn during the past decade has exposed more people to factors, such as unemployment, that may lead to adverse mental health problems.

Hypothesis: Prevalence of depression has increased over the past six years due to the economic downturn in 2008.

Methods: We used data from the National Health and Nutritional Examination Survey (NHANES) for years 2005-2006, 2007-2008, and 2009-2010. The NHANES is a continuous survey which collects data on measures of health and nutrition in representative sample of non-institutionalized U.S. population. The analysis was limited to individuals aged 18 years and older. Depression was categorized as major, current and other depending on symptoms including in category. Major Depression was defined as self-report of symptoms that lasts for more than half a day to nearly every day for at least past two consecutive weeks. Major Depression includes at least 5 of 9 self-report symptoms (1: Little interest in doing things, 2:Feeling down, depressed, or hopeless, 3:Trouble sleeping or sleeping too much, 4:Feeling tired or having little energy, 5:Poor appetite or overeating, 6:Feeling bad about yourself, 7:Trouble concentrating on things, 8:Moving or speaking slowly or too fast, 9:Thought you would be better off dead) and at least either little interest in doing something or feeling down. Other Depression is defined if they meet 2, 3, or 4 of the 9 self-report symptoms including either little interest in doing something or feeling down. Current Depression is defined if they meet criteria of either major depression or other depression. The analysis accounted for the cluster and strata statement of the complex survey design and the sampling weights so that depression prevalence estimates reflect prevalence among the non-institutionalized U.S. population. The NPTREND test was used to determine whether changes in depression prevalence increased linearly during years 2005 to 2010.

Results: In each survey period, individuals with depression were more likely to be white, female and have less than a college education. Major Depression in U.S. population aged >18 years of age was 5.3% in 2005-2006 (n=10,348), 5.9% in 2007-2008 (n=10,149) and 6.6% in 2009-2010 (n=10,537). Other Depression in U.S. population aged >18 years of age was 7.7% in 2005-2006 (n=10,348), 9.6% in 2007-2008 (n=10,149) and 9.3% in 2009-2010 (n=10,537). Current Depression in U.S. population aged >18 years of age was 8.1% in 2005-2006 (n=10,348), 10.2% in 2007-2008 (n=10,149) and 9.9% in 2009-2010 (n=10,537).Test for linear increase in depression prevalence over the six year period was significant.

Conclusion: This study shows that the economic downturn in the U.S. population during years 2007-2008 was accompanied by an increase in prevalence of major depression. This increase in major depression has been sustained through 2010.

P3-29
HETEROGENEITY IN ANTIDEPRESSANT PRESCRIBING PATTERNS BY GENDER, PHYSICIAN SPECIALTY, AND DIAGNOSIS OF DEPRESSION

Lead Author: Kaushal Mehta, M.B.B.S., M.D.

Co-Author(s): David Shoham, PhD; Murali Rao, M.D.

ABSTRACT:
Background: Antidepressants were the third most common prescription drug taken by Americans of all ages during years 2005-2010 and the most frequently used by persons aged 18-44 years. From 1988-1994 through 2005-2010, the rate of antidepressant use in the United States among all ages increased nearly 400%. Reasons for this increase may be use for non-depression related chronic conditions and preferential prescribing of antidepressants to women.

Hypothesis: All things being equal, non psychiatrists are more likely to prescribe antidepressants compared to psychiatrists. Females are more likely to be prescribed antidepressants regardless of depression diagnosis or prescriber physician specialty.

Methods: We used data from the National Ambulatory Medical Care Survey for years 2007 to 2010. The National Ambulatory Medical Care Survey was designed based on a national sample of clinic visits to the non federal employed office based physicians who are primarily engaged in direct patient care. The analysis sample was limited to individuals aged 18 years and older. The statistical analysis accounted for the cluster and strata statement of the complex survey design. Logistic regression analysis was used to determine whether prescribing antidepressants (dependent variable) was associated with physician specialty, diagnosis of depression and patient gender (independent variables). We also explored interactions between gender, physician specialty, and depression diagnosis.

Results: No gender difference was noted in antidepressant prescribing patterns for adults with a diagnosis of depression, but odds of being prescribed an antidepressant was 41% higher among women vs. men for adults without a diagnosis of depression (95% CI 1.27, 1.57). The odds of prescribing antidepressants to patients without a diagnosis of depression were 10-fold higher for psychiatrists compared to non-psychiatrists (95% CI 8.13, 13.13). However, among patients with a depression diagnosis, the odds of prescribing antidepressants was 2.6-fold higher among psychiatrists vs. non-psychiatrists (95% CI 2.11, 3.24). Psychiatrists prescribes antidepressants to 60.5% of patients over age of >18 years. Finally, the study suggests that 46.32% of male & 46.53% of female were prescribed antidepressants by Nonpsychiatrists only after making diagnosis of depression compare to 5.05% of male and 7.07% of female without making diagnosis of depression.

Conclusion: This study shows that antidepressant prescribing patterns differ substantially by physician specialty, diagnosis of depression and by gender. This study suggests that compared to other specialties, psychiatrists may be more likely to prescribe antidepressive medications for indications other than depression. Conversely, non-psychiatrists may be less likely to prescribe antidepressants in the absence of a depression diagnosis.

P3-31
COMPARATIVE EFFICACY OF CBT FOR COMBAT AND NONCOMBAT-RELATED PTSD: A META-ANALYTIC REVIEW

Lead Author: Stephanie D. Guedj, B.A.

Co-Author(s): Lyndsey Zoller, M.S., Dana Barack, B.S., Sean Coad, B.A., Casey Straud, M.S.; Stephen C. Messer, Ph.D.

ABSTRACT:
Statement of the Problem: PTSD confers a significant burden of illness on the person and society due to its prevalence, symptomatic severity and functional impairment, morbidity and mortality risks, and health care utilization and economic costs. A subpopulation at increased risk for the onset and effects of PTSD includes current and past members of the U.S. armed forces, of which approximately 2.5 million have deployed to warzones in Iraq and Afghanistan. Compared to past year prevalence estimates of 3.5% in the general population, studies of active duty/reserve component combat troops obtain rates closer to 14%.

Researchers have responded by developing and evaluating psychological interventions targeting PTSD morbidity. Most trials focused on PTSD related to traumas of sexual/ physical assault, accidents, or natural disasters. Rigorous controlled trials have accrued substantial evidence supporting the efficacy of cognitive behavioral therapies (CBT). Several expert panels have created practice guidelines recommending CBT as the front-line treatment for PTSD.

A paucity of psychological treatment outcome studies with military personnel/veterans exists. Remarkable given: 1) the prevalence and severity of combat-related PTSD, 2) theoretical debate regarding the salience of combat trauma, and 3) reports of "differential treatment response" among those with combat vs. noncombat PTSD. It has been suggested that decreased treatment response, particularly among veterans, reflects the influences of repeated trauma, symptom chronicity, and comorbidity, and combat PTSD may represent a disorder with different mechanisms than noncombat PTSD experienced by civilians. Notably, no study to date has exhaustively and empirically evaluated the evidence regarding differential psychological CBT treatment response among those with combat-related versus noncombat PTSD.

Method/Subjects/Procedure: We conducted an exhaustive systematic review of acute CBT treatment outcome trials for combat and noncombat-related PTSD, building on existing Cochrane Collaboration and Institute of Medicine reviews, while conducting an intensive literature search of relevant databases (e.g., DARE, EMBASE, PsycINFO, PubMed, PILOTS). Random effects modeling was used o compute the combined effect size (Hedge's g), mixed effects analysis and meta-regression examined potential moderators (e.g., age, gender, baseline PTSD severity, baseline Depression, treatment hours, attrition rate, study year)(CMA software).

Results: The combined CBT effect size was substantial, g = 1.15 [0.89, 1.42], p < .0001. CBT efficacy was not significantly different for combat and noncombat-related PTSD, Q (1) = 0.45, p = .50, with highly overlapping 95% CIs, combat PTSD: g = 1.01 [0.50, 1.52], p < .0001, and noncombat PTSD: g = 1.21 [0.89, 1.53], p < .0001.

Conclusions: The clinical "maxim" that combat PTSD is more "treatment resistant" than noncombat PTSD was not supported.

P3-32
POSTTRAUMATIC STRESS DISORDER TREATED WITH VERSUS WITHOUT ADJUNCTIVE EMDR: A QUALITY IMPROVEMENT PROJECT

Lead Author: Ferhana Nadeem, M.D.

Co-Author(s): Carolina Mercader DO1, Ferhana Nadeem M.D.1, Sheraz Riaz M.D.1, Amy Gomez Fuentes M.D.1, Susan Morvey BS2, Jaspal Tatla BS2

ABSTRACT:
Background: Although there have been studies comparing the efficacy of using pharmacotherapy (SSRIs) versus psychotherapy (EMDR), limited studies exist comparing

combination of the two. One researcher presented a combined pharmacotherapy and psychological therapy meta-analysis that concluded evidence was insufficient to support or refute the effectiveness of combined therapy and urged further randomized trials (Hetrick et al., 2010). Similarly in another study, an eight week trial that compared EMDR with fluoxetine and a placebo found that 88% of EMDR, 81% of fluoxetine, and 65% of placebo patients lost their PTSD diagnosis.

Objective: This retrospective analysis is a quality improvement project designed to create awareness of the efficacy of adding EMDR therapy to conventional pharmacological treatment.

Methods: Our selection criteria included patients of any age or gender with an Axis I diagnosis of acute or chronic PTSD with follow-up care in our outpatient clinic between 2008 and 2012. Charts were reviewed and data was collected from electronic medical records for each of the non-EMDR and EMDR subsets. Measure of outcome included medication history (dosage titration, augmentation, or substitution), tally of outpatient visits and inpatient hospitalizations. These results were statistically analyzed for each outcome measure utilizing calculation of mean, 95% CI, mean difference between groups, and t-test (two-sample, two-tailed distribution, unequal variance) to determine statistical significance (i.e. p-value<0.05).

Results: A total of 15 EMDR patient charts analyzed yielded an outpatient follow-up mean of 14.4 visits/year (95% CI= 8.2-20.6), inpatient hospitalization mean of 0 hospitalizations/year, and a medication changes mean of 8.2 changes/year (95% CI= 3.5-12.8). In the non-EMDR data set where n=58, patient charts yielded an outpatient follow-up mean of 15.3 visits/year (95% CI=11.4-19.2), inpatient hospitalization mean of 0.6/year (95% CI=0.3-.8), and a medication changes mean of 1.0 change/year (95% CI=0.7-1.3). Although the mean number of outpatient follow-up visits/year remained greater in the non-EMDR group with a mean difference of 0.9 visits/year, the differences were not statistically significant (p-value=0.23).There was a mean difference of 7.2 medication changes/year more in the EMDR group with statistical significance (p=0.01).

Conclusions: Adjuvant EMDR therapy reduced inpatient hospitalizations by 0.6/year, a statistically significant result. The addition of EMDR increased medication changes per year by 7.2. The small EMDR sample group and comorbid psychiatric conditions among this subset may have accounted for this discrepancy. In conclusion, larger studies are further needed to more accurately assess the qualitative efficacy of adjunctive EMDR therapy in PTSD patients.

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P3-33
GENDER-SPECIFIC PREDICTORS OF POOR MENTAL HEALTH IN PATIENTS WITH ADULT DEPRESSIVE DISORDERS

Lead Author: Roopali Parikh, M.D.

Co-Author(s): Yusef Canaan, MD, Luxi Ji, MPH, Mario Cuervo, MD

ABSTRACT:
Background: It has been widely documented that there are gender differences in depression prevalence, with women experiencing major depression about twice as often as men. In this study, we sought to describe if gender was predictive of poor mental health in adults diagnosed with a depressive disorder and to identify the differential predictors of poor mental health in men versus women in this population.

Methods: The 2008 Centers for Disease Control's Behavioral Risk Factor Surveillance Survey was utilized to identify a cohort of 8,025 patients that reported being diagnosed with a depressive disorder. Demographic data and clinical history were recorded from these patients. The primary outcome of interest was a composite of poor mental health, defined by having five or more of the following for at least 8 days over a 14 day period: depressed mood, disinterest, lack of energy, lack of concentration, change in appetite, and change in sleep patterns. These six symptoms were also combined to form a mental health score.

Results: Among 8,025 patients studied, a total of 5,987 (74.6%) were women while 2,038 (25.4%) were men. Female patients reporting a depressive disorder tended to be younger (52 vs 53 years, p=0.002), Hispanic (5% vs 4%, p=0.019), unmarried (54% vs 49%, p=0.001), and unemployed with lower salaries. They also reported higher rates of financial barriers to medical care (22% vs 18%, p<0.001) with more recent checkups. Female patients also had higher rates of smoking (47% vs 42%, p=0.008), but lower rates of binge drinking (23% vs 32%, p<0.001), high-risk sexual behavior (4% vs 5%, p=0.017), diabetes (14% vs 17%, p<0.001), prior heart attack (6% vs 13%, p<0.001), prior stroke (6% vs 8%, p<0.001). Women reported higher rates of little energy (40% vs 36%, p=0.001) and change in appetite (23% vs 17%, p<0.001) and lower rates of difficulty concentrating (15% vs 17%, p=0.035). No significant difference in mental health score was noted between both genders. In multivariate analysis, gender was not predictive of poor mental health (p=0.219). However, independent predictors of poor mental health were distinct in each gender and included smoking, employment status, prior stroke, financial barriers to care, marital status, and body mass index in the female group and employment status, financial barriers to care, marital status, education, and Hispanic ethnicity in the male group.

Conclusions: In adults diagnosed with a depressive disorder, (1) gender is not predictive of worse mental health and (2) disparate predictors of poor mental health exist in men and women.

P3-34
THE PREVALENCE OF DEPRESSION AND THE FACTORS THAT LIMIT ITS RECOGNITION AND TREATMENT IN ONCOLOGY PATIENTS

Lead Author: Kevat Bansibhai Patel, M.D., M.Sc.

Co-Author(s): Jason Domogauer; Rashi Aggarwal, M.D.

ABSTRACT:
Intro: Depression remains a highly prevalent mental health illness within the oncology patient population, yet the full burden of this disease continues to be poorly understood. Within the general population depression is found to occur at a rate of approximately 6.7% (1), whereas depression in the oncology population has been found at rates between 13% (2) and 39.6% (3). Despite the increased need for depression treatment within the oncology population, several studies have found high rates of under-diagnosis and under-treatment of depression. Therefore, research efforts have been focused on identifying factors associated with patient avoidance of mental health treatment, poor treatment and/or medication adherence, and premature discontinuation of treatment. Additionally, the symptoms of depression can overlap with other disease processes and/or present in a nontraditional fashion depending upon the co-morbid illness. Untreated depression is likely to result in a decreased quality of life for this already vulnerable population.

The aim of this poster is to highlight the key recent research findings on the prevalence of depression in the oncology populations, with a specific focus being devoted to examining the occurrence and potential causes of under-diagnosis and under-treatment of depression.

Results: There exists several barriers that may contribute to the under-recognition and treatment of depression in oncology patients, which include; the perception that all cancer patients are depressed; misconception that depression is a normal part of the oncology disease process; difficulty in distinguishing between depression and normal sadness; somatic symptoms of depression closely mirror the physiologic symptoms of cancer; and clinicians are often fearful of fully exploring psychiatric symptoms at a vulnerable time in a patients' life (4).

Discussion: Several barriers often make depression diagnosis and management in oncology patients a complex and confusing process, which likely contributes to the high rates of under-diagnosis and under-treatment of depression.

Identifying the symptoms of depression is quite a formidable task. It has been known that structural interviews can accurately diagnose depression (5). Unfortunately, structural interviews are time-consuming, and require skill and attention to detail (6). Therefore, a more effective screening method must be utilized, so that a greater number of patients can be diagnosed and treated for their depression.

The lack of diagnosis leads to under-treatment, which may lead to decreased quality of life. Furthermore, the lack of diagnosis and treatment may also be related to patient reluctance to tell their doctors about depressed mood, not wanting to be labeled with a stigmatizing mental health diagnosis, and/or worry about the side effects of antidepressants (7). This has not been extensively studied in the oncology population.

P3-35
SOCIAL CHALLENGES AND GAINING COMPETITIVE EMPLOYMENT FOR VETERANS WITH PTSD: AN EXPLORATORY MODERATOR ANALYSIS OF SUPPORTED EMPLOYMENT INTERVENTION

Lead Author: Swati Poddar, M.D.

Co-Author(s): Lori L. Davis, M.D.; Patricia Pilkinton, M.D., MSc, FRCPC; Catherine Blansett, PhD; Pamela Parker,M.D.

ABSTRACT:
Background: In a randomized controlled trial (RCT), 85 unemployed veterans with posttraumatic stress disorder (PTSD) were prospectively randomized 1:1 Individual Placement and Support (IPS) supported employment (SE) or treatment-as-usual in the Veterans Administration (VA) Vocational Rehabilitation Program (VRP) for one year. Participants who received IPS were 2.7 times more likely to gain competitive employment, worked more weeks, and earned more wages. Social challenges such as lack of transportation, inadequate housing, family care burden, and inadequate financial means may have a negative impact on the outcome to treatment with a vocational rehabilitation program . This analysis explored these issues.

Methods: A post hoc exploratory analysis was conducted on the primary RCT results to explore possible moderators of treatment outcome. A moderator is defined as a 1) baseline variable (i.e. inadequate transportation, inadequate housing, inadequate financial means, and family care burden), and 2) is uncorrelated with treatment choice (i.e. randomization). The treatment groups are compared to determine if the proposed moderator had a differential effect of treatment outcome (i.e. gaining competitive employment). Due

to the small sample size, the two groups (IPS vs. VRP) were analyzed within each moderator and the number needed to treatment (NNT) was calculated. Approximately four times the sample size would be needed to test a moderator by treatment interaction. In the presence of these four challenges (moderators), it was hypothesized that the IPS would have greater success in gaining competitive employment than the VRP model for Veterans with PTSD despite these challenges.

Results: For the primary RCT, 76% of the IPS participants gained competitive employment, compared with 28% of the VRP participants (NNT= 2.07). The exploratory moderator analysis found that there was a greater IPS supportive employment benefit in gaining competitive employment for those with inadequate transportation (NNT=1.5) and inadequate housing (NNT 1.5). Compared to the RCT main finding, there was no greater difference for those with adequate transportation (NNT = 2.4) or adequate housing (NNT = 2.4). Financial means had no greater benefit. The greatest impact was that of family care burden, in that those without a family care burden had a greater benefit from IPS (NNT 1.4) than those with family care burden (NNT 3.3).

Significance: These results are exploratory and are not intended to guide clinical decision making, but rather are an excellent strategy used to design subsequent trials. Since the IPS specialist is more community-based and more patient-centered than the VRP treatment-as-usual, the IPS intervention may better assist the client in overcoming social challenges,that seemingly hinder one from obtaining competitive employment care burden seems to be a substantial barrier to gaining competitive employment regardless of the rehabilitation method used.

P3-36
THE PREVALENCE AND CORRELATES OF DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) IN ADOLESCENT INPATIENTS WITH BIPOLAR DIAGNOSES

Lead Author: David L Pogge, Ph.D.

Co-Author(s): Martin L. Buccolo, PhD; Philip D. Harvey, PhD

ABSTRACT:
Background: The DSM 5 includes a new childhood disorder called Disruptive Mood Dysregulation Disorder (DMDD). This condition is proposed to be marked by intense temper outbursts superimposed on a background of persistent depressed or irritable mood. Since many admissions of children and adolescents to inpatient care are for temper outbursts and aggression we used a large database of adolescent admissions to examine the prevalence and correlates of adolescents with these characteristics. In line with previous reports of diagnostic issues with bipolar disorder, we focused on this diagnosis.

Methods: During a two-year period 1505 adolescent patients were admitted to a private psychiatric hospital and 259 of these received a diagnosis of bipolar disorder. We selected those cases who were rated by their clinicians as having at least moderate depression at the time of admission, severe symptoms of hostility and explosiveness, but no signs of elation or euphoria at the time of admission. We excluded all cases who had evidence of other possible confounding factors or any missing data on any outcomes measures. Using this proxy definition of possible DMDD we compared the adolescents with and without DMDD on several different variables. These included the frequency of bipolar subtype diagnoses; the likelihood of receiving an intervention involving restraint or seclusion during their admission; the number of restraint and seclusion episodes; global ratings of psychopathology, changes in symptoms during admission, and length of inpatient stay.

Results: 174 cases were available for comparison. Of these, 64 (37%) met our criteria for possible DMDD. Cases with a putative diagnosis of DMDD had a 30% likelihood of experiencing restraint or seclusion during their admission, compared to 20% of cases without this putative diagnosis ($p<.05$). The number of restraints and seclusions averaged 1.5 for DMDD cases, compared to 1.0 for other cases, $p<.05$. DMDD cases had a significantly longer length of stay than other cases, 24.4 vs.20.6, $p<.04$ and global psychopathology rated by their clinicians on the GAF was more severe at the time of discharge (44.5 vs. 50.0). The subtype diagnoses of BPI were bipolar disorder NOS for more than half of the patients in each DMDD subgroup.

Discussion: In this study of adolescent inpatients diagnosed as having bipolar disorder a subgroup without euphoric symptoms who manifest explosiveness, hostility, and concurrent depression can be identified. These cases constitute more than a third of all cases who received a bipolar diagnosis and suggest that the diagnosis of bipolar-I disorder is routinely given to adolescent cases who do not show signs of elevated mood. Cases with this putative diagnosis have a more adverse course of hospital stay and are more symptomatic at discharge than other adolescents treated in the same facility.

P3-37
DIFFERENT TREATMENT MODALITIES FOR MOOD DISORDER IN CONNECTIVE TISSUE DISEASE

Lead Author: Sheraz Riaz

Co-Author(s): Carolina Mercader, D.O., Ferhana Nadeem, M.D., Sheraz Riaz, M.D.,Ulfat Shahzadi, M.D.(Volunteer); MSIII: Katherine Abella-Ramirez, Amanda Andou, Kim Oelhafen, MP

ABSTRACT:
Ehlers-Danlos syndrome (EDS) is most prevalent inherited disorder of collagen biosynthesis. It is not infrequent for these patients to have comorbid psychiatric disorders such as major depressive disorder, generalized anxiety disorder, and substance abuse. Typically the patient's comorbid conditions are treated with antidepressants, benzodiazepines, other drugs and psychotherapy. Mood disorders are common among the connective tissue diseases and tend to worsen, as illness becomes more severe.

Objective: Our goal is to assess treatment modalities in patients who have co morbid medical condition like connective tissue diseases along with mood disorders.

Methods: A literature search has been done on connective tissue diseases along with a case report on a patient who suffered from Ehlers-Danlos syndrome.

Case Report: JM 25 year old single Caucasian male, unemployed living with mother presented due to self mutilating behavior and suicidal statement. He had depression for more than 2 years feeling depressed, hopeless, and helpless and under lot of stress but no h/o psychiatric hospitalization/tm He was diagnosed with Ehlers-Danlos syndrome having pain in joints and multiple manifestations which required surgery. He was taking sertraline (SSRI), clonazepam oxycodon, soma and avelox.

Discussion: Authors have illustrated that ECT is preferred for severe, life threatening depression, psychotic depression, and when drug treatment is judged more dangerous in Ehlers Danlos syndrome. Even patients with increased intracranial pressure have been safely treated. A patient with refractory depression was treated successfully with bifrontal ECT without any complications.

Reports have suggested that ECT is the next step in SLE patients not responding to common treatment for depression such as antidepressants and psychotherapy.

Among some of the pharmacotherapy, sertraline in rheumatoid arthritis has demonstrated an effective treatment for major depression. Another study yielded a number of interesting findings, there was no difference in the overall effectiveness of the CB-PHARM, AC-PHARM, and CN-PHARM interventions. Major depressive disorder (MDD), have shown positive results when supplementation has been used as an adjunct to standard pharmacotherapy.

Two major psychotherapies have demonstrated effectiveness in the treatment of major depression in patients: cognitive behavioural therapy (CBT), which deals with relations among affect, behaviour, and cognition, and interpersonal therapy (IPT), which deals with interpersonal relationships.

P3-38
COUGH: A NOVEL DOSE-RELATED SIDE EFFECT OF NEW ANTIPSYCHOTIC ASENAPINE, WHICH MAY AFFECT MEDICATION COMPLIANCE

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ABSTRACT:
Introduction: Asenapine is a new atypical antipsychotic for the treatment of schizophrenia and acute mania associated with bipolar disorder. The US Food and Drug Administration (FDA) accepted the new drug in 2007; since asenapine is a fairly new drug, very few data on it is available. This novel antipsychotic is reasonably well tolerated, especially with regard to metabolic effects. The data indicate that it has minimal anticholinergic and cardiovascular side effects. Asenapine presents several advantages over other second-generation antipsychotics, such as sublingual formulation, early efficacy and good metabolic tolerability.

However, an extensive search using the keywords cough and asenapine revealed no data or case report suggesting cough is related to asenapine treatment.

We would like to present a case that developed cough after increasing the dose of asenapine.

Methods: Case presentation and literature review.

Results: This is a 53 y/o female with a past psychiatric history of Bipolar disorder type 1 who presented to the outpatient psychiatric clinic. On initial evaluation patient was on asenapine 5 mg PO nightly. Since the patient showed limited response to the 5 mg dose, asenapine was increase to 10 mg PO nightly. After the dose was increased the patient started to have a dry cough. The patient had no history of smoking, alcohol consumption, other associated pathology or drug intake. There was no history of such an episode in the past or any medication allergy. Clinical examination revealed a clear chest and no signs of pulmonary infection. Investigations revealed normal X-ray chest and sinuses. All basic investigations like eosinophilic count, CBC, urine analysis, CMP and ECG were normal.

Conclusion: We identified in our case that cough occurred after increasing the asenapine dose. The Naranjo algorithm was used to determine if it was actually due to the drug rather than the result of other factors. The score was 5, which is consistent with a probable adverse drug reaction.

On September 2011 the FDA released a warning to the

public that serious allergic reactions have been reported with the use of the antipsychotic medication asenapine maleate. A search of the FDA's Adverse Event Reporting System database identified 52 cases of Type I hypersensitivity reactions. Signs and symptoms of Type I hypersensitivity reactions may include anaphylaxis (angioedema, low blood pressure, rapid heart rate, swollen tongue, difficulty breathing, wheezing, or rash). Our patient did not present any of the above-mentioned symptoms. The patient only presented a dry cough that improved after five to ten minutes.

This case not only provides additional information about potential new side effect of Asenapine usage, but also enables clinician to foresee potential obstacle in medication compliance with higher dosage of this medication, which would be essential for better management of psychiatric illness.

P3-39
TELEPSYCHIATRY FOR THE TREATMENT OF MOOD DISORDERS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Lead Author: Nikita Shah, M.D.

Co-Author(s): Sara Polley, M.D.; Sara Jeurling, M.D.

ABSTRACT:
Context: Telepsychiatry in clinical practice has been advancing for almost 50 years. Clinicians need to understand its advantages and limitations.

Objective: This article summarizes the literature comparing psychiatric treatment of adults with affective disorders via telepsychiatry versus traditional treatment. Primary outcome measures include symptom scores based on clinically-validated rating scales at initiation and termination of interventions.

Data sources: Randomized controlled trials (RCTs) through December 14, 2012 were identified via systematic literature search of English-language articles in PubMed, Cochrane Library, and PsychInfo databases. Other sources included bibliographies of related articles and Google.

Study selection: RCTs were selected in which patients with affective disorders were exposed to telepsychiatric treatment versus face-to-face treatment, with comparisons of symptom scores before and after the intervention. Searches yielded 210 articles, of which 4 met all eligibility criteria (1057 participants). Disagreement between two independent reviewers was resolved by consensus. Chance-corrected agreement between reviewers was found to be excellent with a Kappa statistic of 0.806.

Data extraction: Three reviewers performed data extraction independently. Effect sizes were represented by standardized mean difference, for which 95% confidence intervals (CI) were calculated.

Results: All studies showed telepsychiatry to be as effective as face-to-face treatment for affective disorders; overall effect size was 1.15 (CI 0.95,1.41). In determining the overall quality of this meta-analysis, clinical heterogeneity was assessed. Regardless of the outcome measure used, each studies' definition of 'response' was consistent with the accepted definition per tool. Other study aspects such as population, sampling methods, and depression severity were relatively homogeneous across studies. There was a moderate degree of statistical heterogeneity with a chi-squared of 31.5%(Q=4.38, d.f.=3). Results of a funnel plot suggest publication bias is unlikely.

Conclusions: Psychiatric treatment via video-conferencing is at least as effective as face-to-face treatment.

P3-40
BIPOLAR DISORDER AND TOURETTE SYNDROME IN ADULTS- A TREATMENT CHALLENGE

Lead Author: Gurjot Singh, M.D.

Co-Author(s): Manoj Puthiyathu, M.D.

ABSTRACT:
Background: Tourette syndrome(TS) is characterized by chronic multiple motor and one or more vocal tics, has not been well recognized in adults.There are many studies in literature that provides evidence of Bipolar disorder being one of the co morbid disorder in adult patients with TS. Treatment of TS in adults and Bipolar disorder is very challenging and has not been exclusively studied.

Objective: A case report to look for treatment challenges in adult patient with Tourette syndrome with co- morbid Bipolar disorder.

Case report: RS was a 41 year old Caucasian male, single, living alone in an apartment, unemployed, had history of Bipolar I disorder >3years, Alcohol dependence with physiological dependence, Sedative-Hypnotic abuse and TS , was last evaluated in outpatient department for regular follow up. He was very satisfied and compliant with the medications and had been regularly following up in the outpatient clinic. Patient's medication included Pimozide 1 mg P.O BID , Quetiapine 100mg P.O BID, lamotrigine 50 mg OD, Clonazepam 1 mg TID . His past psychiatric history included history of Tourette syndrome since childhood with predominantly motor and intermittently vocal tics. He had documented history of legal charges, 3 DUIs, assaultive behavior with family and greater than 5 inpatient psychiatric hospitalizations. He also had history of two suicidal attempts in the past, last one was three years ago when he tried to cut his neck with a knife and required sutures at that time. His substance history included Alcohol and sedatives-hypnotics abuse (takes more than the prescribed dose of clonazepam) for 2 years. He had no history history of DTs, detoxifications or rehabilitations in the past.

Discussion: Treatment of TS in this patient had been very challenging because of co- occurring Bipolar disorder and Substance Abuse. The challenge in the treatment of this patient was Pimozide can interact with Quetiapine and increases the risk for prolong QT syndrome. The other challenge was Lamotrigine, a FDA approved for Bipolar disorder- depressive type, was very effective for the patient but according to a case- study in literature, it can provoke symptoms of TS. The third challenge developed when patient started abusing Clonazepam that made the treatment management even more difficult.

Patient was followed up after two months after keeping him on same regimen with regular monitoring. He remained compliant to his medications with no exacerbation of symptoms and no hospitalizations reported. The plan was made to closely monitor the QT prolongation by following up with regular EKGs. Patient was given psych-education regarding Clonazepam abuse and will be monitored for any further abuse. Patient will be following up in outpatient clinic once every month.

This case was a good illustration to show us the complications and challenges we can face in an adult patient with TS with co-occuring Bipolar disorder and substance abuse.

P3-41
RESURRECTING PSYCHOTHERAPY IN PSYCHIATRIC PRACTICE: A CLINICAL VIGNETTE

Lead Author: Poonam K. Thandi, M.D.

Co-Author(s): Farzana Bharmal, M.D.

ABSTRACT:
Introduction: Major depressive disorder affects many domains within an individual's life. As important and effective psychotherapy has shown to be, an ever decreasing number of psychiatrists are incorporating it into their practices. Depression is multifaceted and psychotherapy remains an important aspect of treatment.

Case Description: This is a 40-year old previously highly functioning woman. She has a history of intractable temporal lobe seizures, requiring subpial resection of the left hippocampus and subtotal resection of the left amygdala. She presents as an outpatient for her first appointment after being hospitalized for suicidal ideation.

She reported sadness, anhedonia, worthlessness, and poor appetite. She had difficulties sustaining energy or concentration. She often had thoughts of death. She had insomnia and was kept awake by ruminations of regret over the functional decline she experienced after neurosurgery.

The client was calm but guarded. Eye contact was poor. She was unkempt. She had poor content and spontaneity of speech. Mood was depressed and affect was blunt. There were no delusions or perceptual disturbances. Fair judgment and limited insight. No active suicidal ideation.

In addition to pharmacotherapy, we began the process of psychotherapy. Initially she was closed off and disengaged from the therapeutic process. Her personal defense structure was manifesting itself as resistance. Although this resistance initially served as a barrier to therapy, it was later accepted into the process and we explored it further. We discussed underlying automatic thoughts. As these thoughts were brought toward the forefront of her consciousness, a curiosity was fostered within her that served as the building blocks of insight. Our therapeutic relationship strengthened. Speech became more spontaneous. She had a broader range of affect. Personal hygiene improved. We started discussing her vulnerabilities and uncovered underlying cognitive distortions. Over several months her level of functioning improved and she began to identify personal goals. She continues to engage in weekly therapy.

Discussion: This case highlights the importance of psychotherapy in the treatment of major depressive disorder. Often our patients have developed maladaptive defense mechanisms that serve as resistances in therapy. Accepting these defenses into the therapeutic process can serve as a vehicle in fostering insight.

Pharmacotherapy has its advantages, but the benefits of psychotherapy are not to be overlooked. It is a fundamental component in the treatment of mental illness. As the landscape in the field of psychiatry changes, let us not lose perspective on the role of psychotherapy. A strong therapeutic relationship can facilitate discussions of firmly established defense mechanisms and cognitive distortions. It can provide insight and help the client make lasting changes in a way that other options fall short.

P3-42
BUPROPION VERSUS METHYLPHENIDATE IN THE TREATMENT OF ADHD: A SYSTEMATIC REVIEW AND META-ANALYSIS OF PLACEBO-CONTROLLED TRIALS

Lead Author: Jennilee Tuazon, M.D.

Co-Author(s): Reetta Marciano, M.D., MSN, Aruna Kodali, M.D., Seth Himelhoch, M.D., MPH

ABSTRACT:

Background/Objectives: Attention Deficit Hyperactivity Disorder (ADHD) is a disorder with a worldwide prevalence approaching 6 percent and has significant impact on an individual's socio-occupational functioning, as well as strong associations with other major mood and substance disorders. First-line treatment includes psychostimulants which have strong abuse potential and myriad side effects. Given comorbidity with mood disorders, bupropion has been offered as an alternative to address both ADHD and mood symptoms. The aim is to examine the literature available regarding the use of methylphenidate versus bupropion in the treatment of ADHD.

Methods: Systematic review and meta-analysis utilizing electronic databases (PubMed and PsycInfo) and grey literature. English-language articles of randomized, controlled clinical trials of bupropion vs. methylphenidate in adults over 18 years with a diagnosis of ADHD were searched, with 45 studies excluded out of 50. After full-text review (kappa=1), two studies met selection criteria and response rates were rated by the Clinical Global Impression-Improvement scores (CGI-I), with scores of 1 or 2 being significant. The difference in mean change in scores was used to tabulate the final results. All studies were evaluated for risk of bias per the Cochrane method.

Results: This quantitative review encompasses data from two studies totaling 128 participants after screening for eligibility. The participants included adults and primarily involved males rather than females. One study was 12-weeks in duration (Levin et al 2005) while the other was 7 weeks, with a 7-day placebo lead-in period (Kuperman et al 2001). Neither study showed significant difference between the active treatment groups compared to placebo on Forest plot.

Discussion: The results showed significant heterogeneity between studies indicative of poor internal validity. The evidence base for bupropion management of ADHD versus placebo and methylphenidate is lacking. More studies involving head-to-head comparisons with uniform measures are needed.

P3-43

INTEREST IN TREATING MAJOR DEPRESSIVE DISORDER WITH TRANSCRANIAL MAGNETIC STIMULATION IN THE OUTPATIENT MENTAL HEALTH SETTING: WHAT'S THE ATTRACTION?

Lead Author: Jeffrey M Turell, M.D., M.P.H.

Co-Author(s): John Skalla, PhD

ABSTRACT:

Background: When treating Major Depressive Disorder several options exist, each with pros and cons. Due to undesirable side effects and limited efficacy of antidepressants, and cognitive side effects and anesthesia requirements of ECT, new treatments continue to be developed. Transcranial Magnetic Stimulation(TMS) is now FDA approved for treatment of MDD that has failed at least one antidepressant. Yet, TMS treatment is not covered by most insurance companies. So the question remains, given the improved efficacy over medications, and a favorable side effect profile compared to both medications and ECT, are people willing to self-pay for a course of TMS treatment, ranging from $2,000 up to $7,500 or more?

Methods: To answer this question, a survey was developed at a private outpatient mental health practice, then field-tested. Patients diagnosed with major depressive disorder, age 18-64, were offered a survey in the waiting room. The patients provided informed consent. A survey number was linked to their name, which was only written on the informed consent. Descriptive statistics and correlations were calculated.

Results: At the time of analysis, 31 patients completed the survey. Mean age was 44.5 years old; 80% of the respondents were female. 61% report some college education or higher. 74% have a household income over $50,000. 77% of respondents report remaining depressed despite treatment with an antidepressant for 8 weeks or longer(Efficacy of treatment in 23% of respondents). 42% of respondents report experiencing side effects severe enough to discontinue treatment. 32% of respondents were interested in receiving TMS were it available to them, yet 100% reported they were not willing to self-pay for the treatment, with treatment estimates provided at $300 per treatment, 25 treatments in all, $7,500 for the total cost of treatment. Given the option, nearly 10% of respondents were willing to spread the payments out over 24 months at $300/month, or to take out a credit card offer with 0% interest ranging from 12-18months in order to pay for the TMS treatment. Were insurance willing to subsidize the TMS treatment cost, 61% of respondents showed interest in proceeding with TMS treatment.. Only about 13% of respondents have a Flexible Spending Account, which could be used to pay for up to $2,000 of the cost of treatment. Nearly 30% of respondents wanted to be contacted when TMS became available locally. When given lower price points as options, nearly 10% reported willingness to pay $100/session(Total treatment cost $2,500), and 3% were willing to pay $150/session(Total treatment cost $3,750). Only 22% of respondents reported interest in going to another provider for TMS. Corr=0.373 between failed antidepressant treatment and interest in TMS, with p=0.019.

Conclusion: Interest in TMS exists when antidepressants have been ineffective, but self-pay is a barrier to treatment, with greater interest at a lower price point.

P3-44

BREAKTHROUGH LEFT PARAFALCINE MENINGIOMA IN A PATIENT WITH BIPOLAR DISORDER: A MISSED DIAGNOSIS

Lead Author: Atika Zubera, M.D.

Co-Author(s): Nicole Guanci, M.D., Rashi Aggarwal, M.D., Gloria Seo, M.D., Raju Shah MS-III.

ABSTRACT:

Background: The prevalence of pathologically-confirmed meningioma is estimated to be approximately 97.5/100,000 in the United States with over 170,000 individuals currently diagnosed with this tumor. Brain tumors may present with multiple psychiatric symptoms such as depression, personality change, abulia, auditory and visual hallucinations, mania, panic attacks, or amnesia. Here we present a unique case of a young male presenting with impulse control problems, initially requiring an inpatient psychiatric admission, who was later found to have a meningioma causing his psychiatric symptoms.

Case presentation: Mr. RT is a 37 year old male with no past psychiatric history and a past medical history of traumatic brain injury status post motor vehicle accident, who presented to the emergency room (ER) with chief complaints of threatening behavior, disorganized thought process, grandiose delusions and over productive speech. He had delusions about going to Los Angeles and becoming famous. He was diagnosed with Bipolar disorder type 1, R/o Schizoaffective disorder and was started on low dose Risperidone, initially at 0.5 mg PO BID and Valproic acid at 250 mg PO BID and admitted to the inpatient psychiatric unit. During this admission, he later developed increasing gait in-coordination with urinary and fecal incontinence after 7 days of his hospital stay. An MRI was done on hospital day 17, to look for any intracranial etiology for unsteady gait, which showed a tumor measuring approximately 5 cm x 5 cm in the frontal region.

Discussion: Frontal lobe tumors, which account for approximately 22% of intracranial brain tumors, have often been associated with behavioral symptoms. The right frontal lobes and the limbic area are reportedly related to secondary mania, but prospective long-term studies involving meningiomas presenting as bipolar disorder are lacking.

Further, psychiatric manifestations may be the initial presentation of intracranial pathology when neurological signs are not present. The absence of neurological symptoms can lead to misdiagnoses and delay in diagnosing and treating the underlying condition. In our case, the patient's condition improved significantly after he underwent the resection of the meningioma and his diagnosis was changed from Bipolar disorder type 1 to Mood disorder secondary to general medical condition. He was started on Haloperidol prn for agitation post operatively but he did not receive any prn medications till his discharge.

Conclusion: It is clear that a more meticulous approach and frequent neurological exams should be undertaken with patients presenting with new onset psychiatric symptoms, to rule out underlying pathogenesis and avoid any missed diagnoses. More prospective long term studies are needed regarding the various psychiatric manifestations of the brain tumors, particularly meningiomas, which may assist the development of guidelines in future for the evaluation of patients with meningiomas.

P3-45

A UNIQUE CASE OF BIPOLAR DISORDER WITH RETARDED CATATONIA DEVELOPING PARKINSONIAN FEATURES: PRIMARY PARKINSON'S DISEASE OR LATROGENIC?

Lead Author: Atika Zubera, M.D.

Co-Author(s): Tamkeen Khurshid, M.D., Samuel O Sostre, M.D. Humaira Shoaib, M.D.

ABSTRACT:

Catatonia is a syndrome characterized by mutism, immobility, excitement, rigidity, negativism, posturing, stereotypy, and/or impulsiveness and is usually seen in multiple psychiatric conditions including bipolar disorder, unipolar major depression, schizophrenia, schizoaffective disorder, or autism spectrum disorders and various medical conditions. Catatonia is characterized by various subtypes: retarded, excited and malignant. Here we present a unique case of a patient with retarded catatonia who developed stage III sacral decubiti with urinary and fecal incontinence, on treatment with atypical antipsychotic medications which included Quetiapine and Olanzapine.

Methods: Case presentation and Literature review

Abstract: Ms. FK a 58 yr old caucasian female with past psychiatric history of Bipolar disorder type 1, MRE depressed with catatonic features, was transferred from another facility for further management and treatment. Patient presented with c/o urinary and fecal incontinence with stage III sacral decubiti ulcers. As per chart review, patient had h/o taking mutliple atypical antipsychotic agents for prolonged period of time. Patient was admitted to the surgical floor under psychiatry for management of her sacral decubiti. Patient was started on Lithium and Bupropion. Patient's Olanzapine was slowly tapered. Patient was also started on Physical therapy. Patient's catatonia slowly improved and she was able to ambulate independently. Patient became more verbal and her sacral decubiti healed completely. Patient however continued to remain incontinent of urine and feces. Neurological consultation revealed that patient had parkinsonian

features with differential diagnosis being primary versus iatrogenic parkinsonism.

Discussion: Catatonia presents in approximately 10-15% of acute psychiatric inpatients. Literature review revealed controversial results on the use of atypical antipsychotics and in fact detrimental effects of usage of typical antipsychotics. Here we present a unique case of retarded catatonia in a patient with Bipolar disorder who developed urinary and fecal incontinence with sacral decubiti ulcers while being treated with atypical antipsychotics including Quetiapine and Olanzapine for prolonged period of time. Neurological evaluation revealed that patient had parkinsonian features which might be primary versus iatrogenic secondary to long term use of atypical antipsychotics.

Conclusion: Catatonic patients should be carefully screened for underlying medical or neurological disorder as an etiology with cognitive testing and other lab work. Catatonic patient's with Bipolar disorder on atypical antipsychotics should be monitored for any parkinsonian side-effects of the medications. This poster emphasizes the need for prospective double blind placebo controlled trials of usage of antitypical antipsychotics, Quetiapine and Olanzapine in particular, in the treatment of Bipolar patients with retarded catatonia.

POSTER SESSION 4

P4-01
FACTORS ASSOCIATED WITH REPEATED VISITED TO A PSYCHIATRIC EMERGENCY SERVICE IN NIGERIA

Lead Author: Abosede Adekeji Adegbohun, M.B.B.S., MWACP

Co-Author(s): Dr Increase Ibukun Adeosun, M.B,B.S, FWACP

ABSTRACT:
Introduction: Studies have shown an upsurge in visits to Psychiatric emergency services (PES) and a trend towards overcrowding. Patients who repeatedly utilize the PES rather than attending routine out-patient care facilities disproportionately consume services and exert burden on mental health resources. On the other hand patients may repeatedly utilize PES due to unmet needs in other compartments of the mental health service network. Literature search revealed a research gap on the extent and factors associated with multiple use of PES in Africa.

Objective: This study assessed the factors associated with repeated visits to a PES in Nigeria.

Method: The study was conducted at the Emergency Department of the Federal Neuro-Psychiatric Hospital Yaba, the only 24-hour facility based Psychiatric emergency services in Lagos, Nigeria. We defined repeated visits to the PES as 2 or more attendances within a 6 month period. The database of 2,612 consecutive visits to the PES between January and June 2012 was reviewed. The sociodemographic and clinical characteristics of repeated and non-repeated service users were compared.

Results: Patients with repeated visits accounted for 32.6% of total attendance at the PES. Factors associated with repeated visits to the PES included being unmarried (p=0.012), presence of psychotic symptoms (p=0.016), history of substance abuse (p=0.041), defaulting from out-patient clinic (p<0.001) and lack of funds to procure medications (p=0.013). Repeated visitors were more likely to be hospitalized (p=0.037).

Conclusion: Socioeconomic disadvantage and non-engagement with routine outpatient care contribute to repeated utilization of PES in Nigeria. Efforts to minimize the revolving-door cycle of PES visits must address these issues.

P4-02
IS THERE AN ASSOCIATION BETWEEN GASTRIC BYPASS SURGERY AND ALCOHOL USE?

Lead Author: Hilla Azoulay, M.D.

Co-Author(s): H Azoulay M.D.,Dr A Frometa,Dr J Kearse,Dr R Rehmani,Dr.U Shahzadi M.D., Neil Poulsen MS, Daniel Poor MS.

ABSTRACT:
This report highlights the post bariatric surgery effect on alcohol use disorders, metabolism and consumption Although bariatric surgery may reduce long-term mortality and it carries a low risk of short-term serious adverse outcomes, reports have emerged that raise concerns that patients may be at increased risk for developing an alcohol use disorder (i.e., alcohol abuse and dependence)(2). Alcohol-use disorders are associated with depressive episodes, severe anxiety, insomnia, suicide, and abuse of other drugs.

Case Report: DK 41years old female with psychiatric diagnosis of mood disorder NOS,borderline disorder, history of alcohol abuse with physiological dependence brought by police department to ER after making suicidal comments and exhibiting behavior of intoxication and aggression following driving car into train tracks.

The patient reported while she was intoxicated with alcohol, she tried to drive her car to railway track and jump in front of the train. However, she could not do it because she was unable to get out of her car while on the railway track. A passer by rescued her from the site when he noticed that she was in danger and her car was hit by the train.She had suicidal attempt in past with over dosage of ambien tablet. No history of self-mutilating behavior and assaultive behavior. Patient had history of hypertension, liver cirrhosis, psoriasis and underwent gastric bypass surgery in 1988.

Discussion: Researchers reported in a Prospective Cohort Study that although the 2% increase(7.6 percent to 9.6 percent) in prevalence of AUD from prior to surgery to the 2 year post operative assessment may seem small, the increase potentially represents more than 2,000 additional people with AUD in the United States each year, with accompanying personal, financial, and societal costs.(1).Variables associated with increased AUD are male sex,younger age, and numerous pre-operative variables (i-e smoking, regular alcohol consumption, recreational drug use, and lower interpersonal support) and undergoing a Roux-en-Y gastric bypass procedure(10).(2),(4)

After bariatric surgery changes in alcohol's pharmacokinetics may alter not only the bioavailability and stimulating properties of alcohol but may also influence the neuronal and hormonal signals upstream of the reward system(5). Recent imaging studies have revealed changes in RYGB patient's dopamine D2 receptor expression in the ventral striatum and caudate nucleus an area involved in alcohol rewarding effects and also associated with susceptibility for alcohol use and abuse. Hormones that have been shown to change after RYGB such as leptin and ghrelin are also known to modulate the dopaminergic reward system as well as alcohol consumption (6).(7)(8)

P4-03
POSTTRAUMATIC STRESS MODERATES THE ASSOCIATION BETWEEN PAIN AND SYSTOLIC HYPERTENSION IN WOMEN BUT NOT IN MEN

Lead Author: Jagadeesh Batana, M.B.B.S.

Co-Author(s): Samir Qasim, M.D; Danish Fakhar, M.D; Donald S. Ciccone, Ph.D.

ABSTRACT:
Introduction: Research has shown that individuals with casual high blood pressure have diminished sensitivity to an experimental pain stimulus. At the same time, a separate line of inquiry has shown a high prevalence of clinical pain among individuals with posttraumatic stress disorder (PTSD). Since hyperarousal due to activation of the central noradrenergic system is both a symptom of PTSD and a possible cause of high systolic blood pressure (SBP) it is possible that the two findings may be related. The aim of the present cross-sectional study was to determine whether differences in posttraumatic stress moderate the association between pain and blood pressure in patients seeking primary medical care.
Method. A self-report questionnaire was administered to a consecutive series of outpatients seeking primary medical care at an inner city teaching hospital (N = 285). All participants provided informed consent and were fluent English speakers aged 18 and above. The survey included validated screens for PTSD and depression along with questions about pain intensity and duration. Blood pressure readings contemporaneous with survey data were obtained from the medical chart.

Results: Patients with high SBP (>140) were significantly less likely to report pain than patients who were normotensive (< 120), 67.6% vs 84.0% respectively (p<.01). As expected, those with high levels (>median) of posttraumatic stress symptoms (PTSS) were more likely to report pain compared to those with fewer symptoms, 88.1% vs 67.8% (p<.01). The mean pain rating (0-20) for hypertensive women with low PTSS was 2.83 while for normotensive women with low PTSS the mean was 10.28. Corresponding pain scores for men were 5.16 and 6.87. The mean pain rating for hypertensive women with high PTSS was 10.74 while for normotensive women with high PTSS the rating was 11.38. The corresponding pain scores for men were 12.26 and 12.43. A 2 x 2 (Low vs High SBP X Low vs High PTSS) between-groups analysis of variance with pain intensity ratings (0-20) as the dependent variable yielded an overall main effect of SBP for women (F=8.37, p<.01, eta2= 8.8%) but not for men (F<1). This analysis also yielded an overall main effect of PTSS for women (F=10.08, p<.01, eta2= 10.4%) as well as men (F=28.87, p<.01, eta2= 24.1%). The interaction between SBP and PTS was significant for women (F=5.55, p<.05, eta2= 6.0%) but not for men (F<1).

Discussion: The results of this cross-sectional study suggest that hypertensive women (but not men) report less pain than those who are normotensive. Moreover, PTSS appear to moderate the association between pain and systolic hypertension in women but not in men. While hypertension is protective in women with low levels of PTSS (associated with less pain) it is not protective in those with high levels of PTSS. In sum, the effects of high SBP on nociception extend beyond the laboratory to include clinical pain severity in medical outpatients.

P4-04
RACIAL DISPARITIES IN A GENERAL PSYCHOSOMATIC PATIENT POPULATION

Lead Author: Kara Brown, M.D.

Co-Author(s): Dr. Lisa J Rosenthal, M.D., FAPM

ABSTRACT:
Evidence shows that minority patients have been disproportionately represented in inpatient psychosomatic consultation populations. Historically, the limited body of literature

suggests fewer consultation requests were made for minority patients compared to Caucasian patients [1-3]. More recent investigations have suggested a change in this trend, with African-Americans receiving more consultations, while other minority groups continue to be underrepresented. However, many of these studies are limited by small populations or were specific to the geriatric and forensic fields; some include referrals made outside of the hospital [4, 5]. In addition, few studies include patients of Hispanic and Asian backgrounds.

We evaluated the racial demographics of the general inpatient psychosomatic consultation service at a tertiary care, urban, academic hospital: we hypothesized that there was a correlation between the race of the patient and the likelihood of having a request for psychiatric consultation. Of 48,733 inpatients hospitalized over a 10 month period between May 2011 and February 2012, 1101 received psychiatric consultations. These patients were categorized both by race and chart- documented history of prior psychiatric diagnosis. Preliminary data suggests there is a relationship between ethnicity and likelihood of consultation, with African-American patients receiving more consultations, and Hispanic and Asian patients receiving fewer consultations compared to Caucasians. Although these numbers are consistent with some of the more recent research examining disparities between minority and Caucasian patients, this represents a departure from the classic body of literature specific to psychosomatic psychiatry. More importantly, this updated data also suggests a significant deficit in the number of consultations requested for Hispanic and Asian patients. More investigation is needed to examine potential disparities in requests for psychiatric consultation, including physician reason for referral, psychiatric diagnoses, treatment recommendations, follow up with psychosomatic team recommendations and transfer to inpatient psychiatric facilities.

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P4-05
COGNITIVE RESERVE AS A MODERATOR OF OUTCOME IN CHRONIC SCHIZOPHRENIA

Lead Author: Edorta Elizagarate, M.D.

Co-Author(s): Jesus Ezcurra M.D., Natalia Ojeda Ph.D., Javier Peña Ph.D., Olatz Napal M.D., Gemma Garcia M.D., Miguel Gutiérrez M.D.

ABSTRACT:
The cognitive reserve (CR) hypothesis suggests that CR may mitigate the adverse effects of brain pathology. However, the specific role of CR has not been exhaustively explored in schizophrenia. Previous literature in schizophrenia has highlighted the predictive value of cognition regarding functional outcome, mainly based on the present level of cognitive performance, and not the premorbid abilities or the level of CR. We aimed to explore if CR acts as a moderator of the effect of cognitive impairment on functional disability among patients with chronic schizophrenia.

Purpose: To analyze the specific contribution of CR to the resulting level of functional outcome in schizophrenia.

Method: One hundred and sixty-five patients with schizophrenia were assessed for clinical symptoms, CR, neuropsychological profile and functional disability. Assessment included clinical interview, psychiatric evaluation (PANNS, Young Mania Scale, MADRS Depression Scale) neurocognition (attention, processing speed, memory, language, executive functions) and functional assessment (DAS-WHO).

Results: Patients with low CR showed more negative symptoms, higher functional disability and worse performance in processing speed compared to those patients with high CR. Regression analyses showed that CR moderated the effect of processing speed on functional disability total score and 3 out of the 4 domains of functional disability (including self-care management, family contact and vocational outcome). The moderating effect of CR on other cognitive domains, in contrast, was not significant. CR moderated the relationship between processing speed and functional disability, but not among the rest of cognitive domains (attention, verbal memory, verbal fluency, working memory and executive functioning) and functional disability.

Importance/Relevance: CR protected against the effect of processing speed impairment on functional outcome in our chronic schizophrenia sample. Our data replicates in schizophrenia results that have been previously reported in patients with other diseases at the central nervous system.

P4-06
CLOZAPINE AND CARDIOMYOPATHY: A CASE REPORT

Lead Author: Mervat Estefanos, M.D.

Co-Author(s): Leon L. Bernhardt. M.D.; Ronnie G. Swift, M.D.

ABSTRACT:
Introduction: With increasing usage of clozapine in treatment resistant cases of schizophrenia, it is important to shed light on one of the rare side effects of clozapine: cardiomyopathy! A potentially life threatening condition. The purpose of this discussion is to highlight the current prescribing guidelines for initiation of clozapine and the causal relationship between clozapine and cardiomyopathy

Case presentation: This is a case of a 24 y/o healthy man with chronic schizophrenia who has been complaining of distressing auditory hallucinations resistant to many trials of mono and combination antipsychotic therapy. Ultimately, patient was placed on clozapine reaching a maximum daily dosage of 250mg. One year later, the patient presented to the medicine clinic with palpitations. An EKG showed tachycardia. Echocardiography showed his LVEF to be markedly reduced (25-35%) with moderate to severe global hypokinesis of the left ventricle. A coronary angiogram showed no evidence of CAD. The patient was diagnosed with dilated cardiomyopathy. Clozapine was discontinued but it was re-started at a lower dosage and titrated to 100 mg po daily due to the re-emergence of severe psychotic symptoms. Six months later, there was no improvement in his cardiac MRI with LVEF 30%. One year later, clozapine was discontinued and LVEF in echocardiography increased from 30% to 40-50%.

Discussion: It is highly likely that his cardiomyopathy was caused by clozapine .There was no family history of heart disease. The patient has no CAD risk factors. His EKG prior to clozapine initiation was normal. The patient did not have a baseline echocardiogram which would have been helpful in comparing his heart condition before and after the initiation of clozapine. The patient was placed on a beta blocker and an ACE inhibitor but improvement was noted only after clozapine was discontinued. The patient presented to the medicine clinic with tachycardia which is commonly considered a benign side effect from many antipsychotics. Clinicians should be vigilant that high clinical suspicion with tachycardia in patients taking clozapine warrants a cardiac work up.

Conclusion: Clozapine may be associated with fatal myocarditis and cardiomyopathy in physically healthy young adults. The literature shows in some cases that cardiomyopathy improves after clozapine is stopped. For at least the initial four weeks of treatment, patients should be closely monitored for nonspecific symptoms such as fatigue, flu like symptoms, tachycardia with EKG at baseline, vital signs at each visit, and then weekly laboratory testing including CPK, troponins, inflammatory markers, a CBC looking for eosinophilia. A baseline echocardiography is not a must but could be crucial in specific clinical situations. Following the guidelines could serve to alert the clinicians of not yet symptomatic myocarditis which if left untreated, might progress to cardiomyopathy, a life threatening condition.

P4-07
THE DEVELOPMENT OF SUICIDAL IDEATION WITH DULOXETINE TREATMENT: A CASE REPORT AND LITERATURE REVIEW

Lead Author: Nicole Guanci, M.D.

Co-Author(s): Rashi Aggarwal, M.D.

ABSTRACT:
Background: In 2005, the United States Food and Drug Administration issued a mandatory warning for antidepressants involving the risk of suicidality in all age groups. For duloxetine, a reuptake inhibitor of serotonin and norepinephrine approved for treating Major Depressive Disorder (MDD), initial clinical trials did not show evidence of an increased risk of suicide. Despite this data, several cases have been reported involving the development of suicidal ideation with duloxetine use, primarily during the initial week of treatment and with titration to higher doses. Here, we present a case involving the development of suicidal ideation after 9 days of treatment with only 30mg of duloxetine.

Case: We present a case of a 25-year-old Caucasian man with a history of MDD and opiate dependence in early partial remission. Prior to the onset of pharmacotherapy, the patient reported mild depression, anhedonia, and no suicidal thoughts. He had not used any illicit substances or alcohol for 3 months. He was started on duloxetine 30mg PO daily. Two days prior to the onset of suicidal thoughts, he experienced decreased need for sleep, racing thoughts, and increased energy. Nine days after starting duloxetine, he experienced sudden-onset suicidal ideation and jumped out of a two-story window, sustaining a pelvic and left acetabular fracture.

Discussion: In this case, the onset of suicidal thoughts was considered consistent with a medication-induced event, since the patient had no prior suicidal thoughts and only mild depressive symptoms. In a meta-analysis of clinical trials for duloxetine by Acharya, et al., there were 5 suicides and 26 attempts of the 4,950 depressed patients treated with duloxetine, which compared favorably with other antidepressants and lead to the conclusion that there

was no significant difference in the incident of suicide with duloxetine versus placebo. However, in a literature review, 7 cases involving the development of suicidal ideation with duloxetine treatment were reported. In this case, the onset of suicidal thoughts occurred after 9 days of treatment (while most reported cases occurred during the first month, the greatest risk was noted during the first week) and on a dose of 30mg daily of duloxetine (unlike the majority of reported cases, which involved doses of 60 to 120mg). Further, this case illustrates the "activation syndrome" previously described in the literature, which refers to symptoms of hypomania after onset of antidepressant treatment, which predispose to suicidal risk. This is postulated to occur as a result of underlying Bipolar spectrum disorders versus more potent serotonin and norepinephrine blockade.

Conclusion: This case not only highlights the potential for emergence of suicidal ideation with duloxetine treatment, but also emphasizes the importance of close monitoring for both suicidality and activating symptoms throughout the course of treatment and even with lower, starting-level doses.

P4-08
RECURRENT STROKES AS A MANIFESTATION OF CONVERSION DISORDER: A CASE REPORT

Lead Author: Abhishek Rai, M.D.

Co-Author(s): Dr. Punitha Vijayakumar

ABSTRACT:
Psychiatric condition generally elude diagnosis ,more if the patient presents with symptoms of medical emergencies such as TIA, Stroke, tumour , spinal cord injuries in which immediate management and relief from the symptoms becomes the priority .

Conversion disorder is one such condition in which the patient presents with one or more neurological disorder. It is very often associated with some stress, emotional conflict or an underlying psychiatric disorder.

We present the case of 52 year old female ,with significant past medical history of chronic migraine and bipolar disorder. She presented to the Emergency room eight times in a period of 2 years .Each time with symptoms of left sided hemiparesis and dysarthria .Out of eight admission she received TPA therapy 2 times. Peculiarly the serial CTScans and MRI Scans did not reveal any signs of stroke. The subsequent neurological examination for left sided weakness and dysatrhia were not compliant with the reporting symptoms. The history of chronic stable migraine was looked in and possibility of complicated migraine was ruled out .

After 8 hospital visits and two rounds of TPA the possibility of some psychiatric condition most probably Conversion disorder was made and hence psychiatry was consulted.

After taking a detailed psychiatric history it was found that she had been a victim of gang rape at age 16 and to worsen the affair her mother and grandmother blamed her for allowing it to happen.Her mother and grandmother were recorded to be suffering fron Bipolar disorder which was never treated all their life.So she has been under a lot of emotionol stress all her teenage and most of her adult hood till she got married.

Due to these tensed situation patient spent most of the time with her grandfather who interestingly had multiple stroke attacks and died of stroke 3 years back which is around the time when her symptoms first manifested.

As a matter of fact TPA treatment predisposes a patient to the complication of bleeding and puts him/her at risk of stroke.Hence this case higlights that the underdiagnosis of conversion disorder can lead to severe iatrogenic complications.Apart from health concerns repeated hospitalisation levy mental and financial burden on the patient and the families.

This case and other like it demands attention and recognition of the medical fraternity ,emergency condition do need aggressive management but at the same time keeping eye out for psychitric condition can do much good.

P4-09
THE PREVALENCE OF SUPERFICIAL MYCOTIC INFECTIONS (ATHLETE'S FOOT) IN A LONG-TERM PSYCHIATRIC FACILITY: A PILOT STUDY

Lead Author: Jacob Kanofsky, M.D.

Co-Author(s): Mary E Woesner M.D., Andres R Schneeberger M.D., Robert Snyder DPM, and J Daniel Kanofsky, M.D., MPH

ABSTRACT:
Based on several studies, there is a significant need to further identify co-morbid medical illness in psychiatric patients and customize treatments to them. The purpose of this study was to investigate the prevalence and progression of one particular cutaneous disease, tinea pedis, at a long-term psychiatric inpatient facility. Twenty six patients at our facility were studied for approximately eight weeks. Clinical exam and mycology culture were used to monitor for tinea pedis infection. At the start of the study, 85% of patients had clinical findings consistent with tinea pedis (scaling, erythema, and maceration) and 63% had a positive fungal culture. The patients then received standard of care treatment as per the hospital (usually medical and podiatry consult followed by topical antifungals for 14 days or more), with many patients participating in educational sessions regarding skin health, hygiene, and disease. After eight weeks, 89% of patients had a positive clinical exam and 84% had a positive culture. This is a high rate when compared to other populations (marathon runners 22%, homeless shelter 38%, and soldiers 61%) and the most resistant to treatment. We believe persistent poor foot hygiene and inadequate treatment compliance with the daily administration of antifungal creams are some of the reasons for these disappointing results. Unique treatment strategies need to be employed with this specific population, particularly those patients with distressing pruritus or at risk for cellulitis. We discuss the staff-observed topical application of a single dose slow-release antifungal preparation and the utilization of copper oxide containing socks as possible treatment options.

P4-10
OPTIMIZING SCRIPTED DIALOGUES FOR AN E-HEALTH INTERVENTION FOR SUICIDAL VETERANS WITH MAJOR DEPRESSION OR SCHIZOPHRENIA: A 'USER DESIGN' APPROACH.

Lead Author: John Kasckow, M.D.

Co-Author(s): S Zickmund, A Walch, A Rotondi, M Chinman, J Cornelius, L Fox, G Haas

ABSTRACT:
Background: Suicide is a health concern among Veterans with major depression and schizophrenia. We had previously developed and pilot tested a Health Buddy® home e-health system that engages at risk veterans with schizophrenia with interactive scripted dialogues. These dialogues query participants about depressive symptoms, suicidality and medication adherence. We adapted the scripted dialogues for Veterans with major depression and tested participants with a history of major depression and suicidal behavior. We compared responses in participants with a history of major depression to those with schizophrenia.

Methods: We convened a panel of experts to develop dialogue content for patients with major depression. For instance, we added the entire 9 questions on the DSM IV criteria for major depression rather than depressive symptoms specific only for individuals with schizophrenia. With regards to questions on psychotic symptoms we included only those symptoms commonly seen in major depression. Usability in the revised dialogues was assessed with 9 outpatients with a history of major depression and a history of suicidality based on standard user centered design methodology. We utilized qualitative analytic methods to determine common themes among participants. Furthermore, we compared responses in participants with major depression to participants with schizophrenia (n = 10).

Results: All 9 participants with a history of major depression completed testing. Both groups preferred greater specificity in question wording especially with questions pertaining to suicide. Both groups also expressed concerns about having the same questions being asked repeatedly. Topics in both groups that elicited a strong emotional response dealt with questions related to suicide, social isolation and family relationships. In addition, both groups expressed concern about whether participants would answer honestly about questions pertaining to suicide and drug/alcohol use. Differences between the 2 groups included the findings that patients with schizophrenia had more trouble with understanding some of the vocabulary utilized. In addition, patients with schizophrenia were more willing to answer more questions per day.

Conclusions: Utilizing user-centered design methodology for telehealth system development in both groups is feasible. There were many common themes as well as differences noted in participant feedback among the 2 groups. The differences between groups are consistent with the cognitive problems that patients with schizophrenia exhibit. The dialogues were revised so as to balance the need to probe for sensitive information vs keeping the process as 'user-friendly' as possible. These results will help inform a larger trial for monitoring suicidality.

P4-11
BRIEF LITERATURE REVIEW AND CASE REPORT OF NEUROPSYCHIATRIC SYMPTOMS IN NEUROMYELITIS OPTICA

Lead Author: Cheryl Ann Kennedy M.D.

Co-Author(s): Ritesh Amin, M.D., Rehman Madraswala, Medical Student IV

ABSTRACT:
A significant improvement in the understanding of the pathogenesis of Neuromyelitis optica (NMO) was reached when an antibody for aquaporin-4 (NMO-IgG) was discovered in 2004 in the serum of NMO patients [1]. Aquaporin-4 (AQP4) is a water-selective transporter expressed in the kidney, lung, stomach, skeletal muscle, and in astrocytes throughout the central nervous system [2]. This disease is an idiopathic inflammatory demyelinating disease of the central nervous system characterized by a predilection for the optic nerves and spinal cord but other brain lesions are known to occur. This report highlights some neuropsychiatric symptoms associated NMO.

Case Presentation: A 41-year-old male who presented to an urban university hospital with NMO and a myriad of psychiatric symptoms. Our patient has a history of and chronic numbness and tingling on the face and both upper and lower extremities along with loss of vision in both eyes. He has a positive serum marker for aquaporin 4 IgG

antibody and on MRI has bilateral hyper-intensity in frontal and temporal lobes. He has developed severe depression, anxiety, insomnia, and hypomania over time of his illness. He reports consistent moderate to severe neuropathic pain and numbness in his extremities.

Discussion: Aside from depression, the literature rarely addresses other neuropsychiatric symptoms associated with NMO despite the increasing recognition that cerebral lesions exist in NMO patients. Two other case reports in the literature mention NMO patients have suffered from delusions of persecution, coprophagia, fluctuating arousal, slow performance on tests of attention with late recall being poor, obsessionality, paranoia, severe insomnia, and polydipsia [3,4]. Brain imaging of the patient confirmed hypothalamic and brainstem involvement. In one report, eye-movement disorder, bulbar dysfunction, and disordered control of respiration were caused by extensive brainstem disease [4]. Awareness and early recognition of the possible neuropsychiatric symptoms associated with NMO may lead to Psychiatric care that may be able to help mitigate the negative impact of this extraordinarily debilitating disease.

P4-12
MILNACIPRAN AND NEUROCOGNITION, PAIN AND FATIGUE IN FIBROMYALGIA: A 13-WEEK RANDOMIZED, PLACEBO CONTROLLED CROSS-OVER TRIAL

Lead Author: Jeong Lan Kim, M.D., Ph.D.

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ABSTRACT:
Objectives: Fibromyalgia characterizes widespread pain and fatigue, and patients reports that they have trouble remembering things, process information less efficiently. This study was designed to investigate whether milnacipran is safe and effective in improving cognitive function in fibromyalgia.

Methods: This was a single-site, block randomized (1:1 ratio) double-blind, placebo-controlled prospective cross-over study. Patients were randomized to receiving milnacipran-washout-placebo or placebo- washout-milnacipran for 6 weeks, followed by a one week washout and then cross over to the other arm for another 6 weeks. The overall trial lasted 13 weeks. Assessments was performed at each visit. Neurocognition was measured by Brief Assessment of Cognition (BAC) and MATRICS. Pain was assessed by Visual Analogue Scale (VAS) for pain. Overall fibromyalgia symptoms was measured by the Fibromyalgia Impact Questionnaire (FIQ) and tender point examination. Depression was assessed by scores on the Beck Depression Inventory(BDI). Fatigue was assessed by the Fatigue Severity Scale (FSS). Functional outcome was evaluated by the Health Assessment Questionnaire (HAQ). The CGI-S and CGI-S and the PCGIC was used to measure global impression of severity and improvement.

Results: 17 subjects completed phase1 and 14 subjects completed phase 2. The mean age was 48.9.±9.8. years, women were 87.1%. The change of Verbal Memory and Composite T score of BAC and the change of Attention-Vigilance Domain T score was significant improved, but there no difference between group. The changes of Clinical Global Impression-Severity (CGI-S) was not significant, but the changes of Clinical Impression-Improvement(CGI-I) was shown worsening in placebo group at week 1(p=0.034), week 2(p=0.026), week 4(p=0.024), and week 6(p=0.60) compared to baseline. The change of Fibromyalgia Impact Questionnaire (FIQ) scores was not significant. The score of Patients Clinical Global Impression of Change (PCGIC) was significant decreased at week 1 (p=0.34) in milnacipran group. The score of Beck Depression Inventory (BDI) was significant decreased at week 1 (23.1 ± 13.5vs 26.5 ±14.8, p=0.007 in milnacipran group. Among 3 subscales of HAQ, the score of disability index was improved at week 1 (p=0.012) and week 2 (p=0.041) in milnacipran group.

Conclusions: the present study indicates the potential benefit and tolerability of milnacipran in treatment of fibromyalgia patients. Milnacipran may have a potential role in improvement pain, disability, and mood. It needs researches on the effect of milnacipran on cognition in fibromyalgia.

P4-13
IMPLEMENTATION OF SCHEDULED MEDICATION POLICY IN PSYCHIATRIC EMERGENCY CENTER ADMISSIONS

Lead Author: Nidal Moukaddam, M.D., Ph.D.

Co-Author(s): Anu Matorin, M.D.; Asim Shah, M.D.; Charlzetta McMurray-Horton

ABSTRACT:
Background: Length of stay for patients awaiting psychiatric admissions in emergency centers (EC) has steadily increased, possibly because of reduction in inpatient psychiatric bed availability. While pending bed availability, patients are housed in emergency rooms, a phenomenon known as "EC boarding". Maintaining treatment continuity and quality of care during EC boarding times is a challenge, particularly in view of the nature of emergency room work, personnel working shifts, and patient agitation.

Methods: Starting December 2011, policy for initiating a scheduled medication regimen on all psychiatric patients in our psychiatric emergency center was implemented. The following key aspects of decision-making were emphasized: Whether patients had a pre-existing psychiatric illness or not, what medications they were receiving (medical or psychiatric), and medical stability. Random chart audits, reminder emails, and reminders during morning rounds were started.

Results: Length of stay in the EC was increased in patients awaiting psychiatric admissions versus patients who were discharged. Staff with regular EC shifts/appointments were the most consistent in implementing the policy. Patients with pre-existing psychiatric disorders on psychiatric medications were the easiest to start on scheduled medications, whereas new patients with no pre-existing psychiatric disorders seen by staff not routinely in the EC were the most challenging group. Implementation rate was 99% on weekdays and 90% on weekends

Conclusions: Starting scheduled medication in the EC for patients awaiting hospitalization is a major measure in optimizing care, as well as a crucial step in maintaining a safe, therapeutic environment in psychiatric emergency rooms. Certain patient populations and staff groups present more challenges to this policy being implemented . Initiating scheduled medication regimens allows a better standard of care, and transforms the EC boarding time into treatment time, rather than a mere gap in care.

P4-14
ACUTE ONSET OF PSYCHOGENIC NON-EPILEPTIC SEIZURES IN A PATIENT WITH CHRONIC INTRACTABLE EPILEPSY

Lead Author: Diana Mungall, B.S.

Co-Author(s): Batool Kirmani, M.D.

ABSTRACT:
We describe a case-report of a young female patient with long-standing epilepsy since childhood. She has failed three resective surgeries, including an anterior left temporal lobectomy, complete total lobectomy, and frontal resection. She has also failed most of the marketed medications, including the vagal nerve stimulator. She continues to remain intractable with two to three seizures per week on tiagabine, carbamazepine, and a vagal nerve stimulator. This was the best control for more than a decade. She was seen in our epilepsy clinic with increase frequency of seizures ranging to 10-20 per day requiring frequent emergency room and clinic visits. Careful history revealed that the presentation of the spells was atypical compared to her usual episodes, and was characterized by head shaking, confusion, electrical sensation in the head, and periods of whole body shaking with no postictal state. She was admitted in our epilepsy monitoring unit and intensive video EEG monitoring was performed for four days. We were able to capture all her spells, which did not reveal any epileptogenic seizures. The diagnosis of psychogenic non-epileptic seizures (PNES) was made with follow up with psychiatry. Our case report emphasizes the importance of intensive video EEG monitoring in patients with well-established diagnosis of epilepsy . The goal is to diagnose new onset frequent atypical events and treat them with the proper therapy. This has the outcome of reducing costly health-care expenditures from frequent emergency room, clinic visits, and hospital admissions that are common in undiagnosed PNES patients.

P4-15
PSEUDOSEIZURES IN PATIENTS WITH CHRONIC EPILEPSY AND MODERATE COGNITIVE IMPAIRMENT: THE NEED FOR VIDEO-EEG MONITORING FOR ADEQUATE DIAGNOSIS

Lead Author: Diana Mungall, M.D.

ABSTRACT:
The objective of our study is to emphasize the importance of intensive video EEG monitoring in patients with well-established diagnosis of epilepsy with moderate cognitive impairment. The idea is to diagnose new onset frequent atypical events prompting the need for frequent emergency room and clinic visits and hospital admissions. Retrospective chart reviews were conducted on patients with chronic epilepsy with moderate cognitive impairment who had increased incidence of new onset episodes different from the baseline seizures. Data were acquired from electronic medical records. Approval for this retrospective analysis of patient records was given by the hospital's Institutional Review Board. We retrospectively analyzed 3 patients with an established diagnosis of epilepsy. Extensive chart reviews were performed with emphasis on type and duration of epilepsy and description of baseline seizures and description of new events. There were two men and one women with moderate cognitive impairment. One subject had generalized epilepsy and other two had temporal lobe epilepsy. The patients were on an average of two to three antiepileptic medicines. The duration of follow up in our neurology clinic ranges from 9 months to 5 years. The occurrence of increased frequency of these atypical events as described by the caregivers, despite therapeutic anticonvulsant levels, prompted the need for 5-day intensive video EEG monitoring. New atypical spells were documented in all three patients and the brain waves were normal during those episodes. The diagnosis of pseudoseizures was made based on the data acquired during the epilepsy monitoring unit stay. Our data analysis showed that intensive video EEG monitoring is an important tool to evaluate change in frequency and description of seizures even in cognitively impaired patients with an established diagnosis of epilepsy for adequate seizure management .

P4-16
THE IMPACT OF IMPLEMENTATION OF A PSYCHI-

ATRIC EMERGENCY DEPARTMENT ON RESTRAINT UTILIZATION

Lead Author: Siva Koppolu, M.D.

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ABSTRACT:

Introduction: Use of restraints is detrimental for patients' physical and mental health. Though it helps in managing agitated patients, adverse outcomes have been reported. Psychiatric emergency departments (PEDs) have been established to improve quality of patient care and safety. However, no studies examined the impact of PEDs, with their specialized approach to management of agitation, on the culture of restraint utilization.

Objective: To determine if implementation of a PED has an impact on the culture of restraint utilization in the general ED. We hypothesize that a PED does have a positive impact.

Methods: Electronic charts of the 250,000 patients that visited 1 year before and 2 years after the opening of a PED (approximately 70,000 adult patients/ year), were searched using the keyword "restraint". Of these, about 1% of cases were restraints that pertained to the management of agitated patients. The outcomes measured included: number of patients in restraints, number of patients placed in restraints without prior medication administration, number of extremities in restraints, duration of restraint episodes, medications, and adverse outcomes. In addition, patient demographics, time of patients' arrival, time of the day restraints were initiated, length of ED stay, years of work experience and gender of physicians ordering restraints are recorded.

Results: Preliminary analyses demonstrate a decrease in restraint episodes and in the average length of stay in restraints. There was an increase in the number of psychiatric consultations called for patients placed in restraints, as well as a decrease in the time between patients' arrival to the emergency room and psychiatry being called. Data review is ongoing to determine whether the availability of having a Psychiatric ED improved the quality and safety of patient care.

Conclusions: The results of this study will guide further steps in implementing hospital wide restraint reduction initiatives that include: cultural changes that relate to restraint usage, enhancement of staff-training in conflict de-escalation techniques and the development of a Restraint Code Team ultimately resulting in decreased restraint related morbidity and mortality.

P4-17

PROFILE OF ADOLESCENTS ATTENDING A PSYCHIATRIC EMERGENCY SERVICE IN NIGERIA

Lead Author: Olufemi Oyeleke Oyekunle, M.B.B.S.

Co-Author(s): Dr Increase Ibukun Adeosun, M.B,B.S, FWACP; Dr Abosede Adekeji Adegbohun, M.B,B.S, MWACP.

ABSTRACT:

Introduction: The Psychiatric emergency service (PES) occupies a central position in the network of mental health services. Evidence from western population, point towards increased utilization of PES by adolescents, particularly in areas with unmet needs for mental health care. There is currently dearth of data on the characteristics of adolescents utilizing PES in sub-Saharan African settings. Recognition of profile of service users is vital in the matching of resource provision with the needs of service users, as well as holistic service planning and policy formulations.

Objective: This study prospectively assessed the socio-demographic and clinical characteristics of adolescents attending a psychiatric emergency service in Lagos Nigeria, between January and August 2012.

Method: The study was conducted at the psychiatric emergency department of the Federal Neuro-Psychiatric Hospital Yaba, the only 24-hour facility based PES in Lagos, a metropolitan city. Following a comprehensive psychiatric assessment, the clinical, socio-demographic and other data regarding the presentation and disposition patterns of consecutive adolescent attendees were entered into an electronic data base and analysed using SPSS-16.

Results: A total of 428 adolescents visited the PES within the 8 month period and constituted 10.3% of the total visits to the PES. Their mean age was 18.9 (± 1.9) years and 56.8% were males. Only 17.9% received orthodox medical treatment before presentation, while the majority presented to traditional and spiritual healers. The median duration of illness before presentation was 36 weeks. The most common diagnoses were schizophrenia (29.4%), Epilepsy (17.5%), Acute psychotic disorder (11.2%) and substance use disorder (10.1%). About 15% required hospitalization, but only 7.5% were admitted due to financial constraints or lack of bed-space.

Conclusion: The emergency room is a major point of entry into mental health care for adolescents in Nigeria; it is also a safety net for adolescents with stigmatized neurological disorders such as Epilepsy. This may be a reflection of health service organization; lack of access to routine mental health services in the community. Furthermore, causal ms-attribution and stigma could lead to delay in appropriate help-seeking until symptoms escalate into crises. To meet the needs of adolescents presenting to PES in Nigeria, the care model must shift from the paradigm of 'triage only' to a model of treatment and integration. Services must be accessible in the community with relevant linkages with the various components of the health service network.

P4-18

EFFECT OF FULL MOON LUNAR PHASE CYCLE ON PSYCHIATRIC EMERGENCY ROOM PRESENTATION IN TERTIARY CARE HOSPITAL SETTINGS

Lead Author: Varinderjit S Parmar, M.D.

Co-Author(s): Ewa Talikowska-Szymczak, M.D., Peter Szymczak, M.D., Erin Meiklejohn, Wasif Habib, M.D., Dianne Groll, PhD

ABSTRACT:

Introduction: Even today, many of us think that mystical powers of the full moon induce erratic behaviors, psychiatric hospital admissions, suicides, homicides and emergency room calls. There has long been a perceived correlation between the effect of lunar cycles on human behavior and illness severity. Studies of the effects of moon cycles on mental disorders and psychiatric emergencies have always been of interest, yet, previous studies on the effect of lunar phases on psychiatric admission rates have been inconsistent.

Purpose: The purpose of this study is to find the link between full moon phases of the lunar cycle and various psychiatric presentations in tertiary care settings, including patients' gender and age within in a five-year time span.

Method: Charts of all psychiatric emergency room patients were reviewed retrospectively. Data for emergency psychiatric visits at 2 tertiary care hospitals was obtained from a five-year period, April, 2006 to March, 2011. Emergency room presentations were divided by ICD -10 criteria into 11 categories. The data was compiled from a computerized log created to record all psychiatric consultations performed by mental health services at these 2 hospitals. Collected data included patients' visit times, dates, genders, ages, and primary diagnosis. The percentage of patients who were evaluated on non-full moon days was compared to the percentage of patients evaluated on full moon days.

Results: In this analysis we compared the clustered diagnoses of participants who presented at the Kingston hospitals during the full moon to those of a control group of patients that did not present on the full moon. Patients were included in the full moon group who presented from 6 pm to 12 am on the first day of the full moon and 12 am to 6 am on the second day of the full moon. A Chi-Squared analysis was used to compare the frequencies of diagnoses in the full moon patients to those of the control group. Age and gender demographics were also observed between the groups.

Conclusion: No significant differences were found between the patients presented on full moon night and the control groups, indicating that there is no change in the frequency of presentation of different diagnoses between these groups.

A significant difference was found between the different age groups. Patients presented to psychiatric emergency on full moon nights are younger than those who presented on non-full moon nights.

There was no significant difference between the gender distribution of the patients presented on full moon and non-full moon nights.

P4-19

SEASONAL VARIATIONS OF PSYCHIATRIC EMERGENCY PRESENTATIONS TO THE TERTIARY CARE HOSPITAL SETTINGS

Lead Author: Varinderjit S Parmar, M.D.

Co-Author(s): Ewa Talikowska-Szymczak, M.D., Peter Szymczak, M.D., Erin Meiklejohn, Dianne Groll, PhD

ABSTRACT:

Background: Referrals to psychiatry account for a large proportion of primary care, and in-hospital medical and paramedical services. Visitations to the ER are often observed to follow certain seasonal patterns. Few studies have focused on seasonal presentations of psychiatric illness in the emergency room setting. Certainly, no significant studies have focused on gathering data on seasonal presentations of psychiatric illness in an emergency department of a tertiary care center

Objectives: To determine seasonal patterns of psychiatric diagnoses presented to the emergency department in tertiary care settings. To examine seasonal variations of basic demographics, such as age and gender, of psychiatry patients presented to emergency room in tertiary care settings. To assist departments of psychiatry to better equip emergency room resources and to better educate the staff and learners based on results of this study.

Methods: Charts of all psychiatric emergency room patients were reviewed retrospectively. Data for emergency psychiatric presentations from 2 tertiary hospitals was obtained from a five-year period.

Emergency room presentations were divided by ICD -10 criteria into 11 categories. The data was first divided according to season (winter, spring, summer, and fall). Seasonal trend of psychiatric diagnoses was studied.

Results: In this study we examined the seasonal difference in emergency room presentations of mental diagnoses. The data was first divided according to season (winter, spring,

summer, fall), and then all seasons were compiled to form a baseline rate, which was then used in comparison with individual seasons. A One-Way ANOVA was first used to determine if there were any differences between the total presentations between the seasons, and it was found that there were no significant differences between the number of presentations.

To examine the difference in age between the seasonal groups, a One-Way ANOVA was completed that compared the average age of people presenting to the ER between the four seasons.

Conclusions: Psychiatry patients who presented in the fall were significantly younger than those who presented in all other seasons. As well, psychiatry patients who presented in the summer were significantly older than those who presented in all other seasons.

The Presentation of psychiatry patients in cluster "substance related disorder" was significantly higher during fall seasons as compared to the baseline. As well, clusters "adjustment disorder", "anxiety disorder" and "others" were significantly lower than baseline during fall seasons.

During fall seasons, as compared to baseline, there were less significant decreases in delirium, dementia and other cognitive disorder, schizophrenia and other psychotic disorders, and somatoform and other dissociative disorders. There were no significant differences amongst the number of presentations in all the four seasons.

P4-20
UNCOMMON COMORBIDITIES WITH TREATMENT REFRACTORY OCD - A DESCRIPTIVE ANALYSIS OF 467 PATIENTS TREATED AT A SPECIALIST OCD SERVICE

Lead Author: Rupal Patel MRCPsych, M.B.B.S.

Co-Author(s): Dr Rupal Patel; Dr Lynne M. Drummond

ABSTRACT:
Background: Obsessive Compulsive Disorder (OCD) is frequently comorbid with many psychiatric and non-psychiatric illnesses. Most common comorbidity seen with OCD is depression and the rate of this particular comorbidity appears to increase with increasing severity of the illness. Research indicates the presence of many other psychiatric comorbidities with OCD like tic disorders, which may have an impact on correct and timely diagnosis, severity of OCD, treatment provision and treatment outcomes. As it is vitally important to understand the rates and roles of such comorbidities in OCD to ensure better care, we decided to look at 467 patients treated over a span of five years at a British specialist centre for the treatment of Obsessive Compulsive and Related anxiety disorders.

Method: We used routinely collected clinical data to perform a retrospective analysis of the comorbid illnesses other than depression, as documented in the electronic case notes of the patients, whose primary diagnosis was noted to be treatment refractory OCD. SPPS was used to record and analyse the data on primary and secondary diagnosis. Only a descriptive analysis was performed as the retrospective nature of the study prevents us from making any other inferences. For the purpose of this study, we defined uncommon as any comorbidity with less than 10% prevalence in our sample.

Results:

Sample size: 467 patients

Females: 52.2%

Males: 48.8%

Comorbid BDD: 6.0%

Comorbid Hoarding: 7.3%

Comorbid Other Anxiety Disorders: 4.7%

Comorbid psychotic disorders (any): 2.1%

Comorbid schizophrenia: 1.1%

Comorbid PTSD: 1.1%

Comorbid personality disorder: 4.3%

Comorbid illicit drug abuse: 1.3%

Comorbid alcohol abuse: 1.5%

Comorbid bipolar illness: 0.6%

Comorbid eating disorder (including disordered eating): 5.6%

Conclusions: These results represent uncommon comorbidities in treatment refractory OCD patients. The long list of varied comorbidities highlights that severe OCD is a complex condition and would require treatment by clinicians experienced in the treatment of OCD. It is important to recognise the role these comorbidities might play in the treatment response and refractoriness of this severely disabling illness.

P4-21
MIRTAZAPINE SUCCESSFULLY USED AS AN APPETITE STIMULANT IN PRIMARY REFUSAL TO EAT IN ADULTS WITH MODERATE INTELLECTUAL DISABILITY

Lead Author: Rupal Patel MRCPsych, M.B.B.S.

Co-Author(s): Dr Richard Hillier

ABSTRACT:
Background: Current research has shown that Mirtazapine has been effectively used to stimulate appetite in the elderly (1). Here we present a case series of four patients with a Moderate Intellectual Disability who each presented with intractable refusal to eat over several months but who did not have overt symptoms of depression according to carers and family. Two of the four patients were being considered by Speech and Language Therapy professionals (SLT) for Percutaneous Endoscopic Gastrostomy (PEG) feeding in view of their significant weight loss and deteriorating physical health.

Results: Mirtazapine was introduced as an appetite stimulant (2), even though there were only minimal symptoms and signs which might have suggested the onset of a depressive episode. All patients experienced an improvement in their appetite within days of initiation of Mirtazapine, increasing their calorie and fluid intake and obviating the need for PEG feeding. During the following 3 months, the patients were also noted to develop an increased interest in activities, improved sleeping pattern and improved concentration.

Conclusion: These patients had very limited communication skills and there was little suggestion of depression at the time of assessment. The families and carers also did not feel that their relative was significantly depressed. Despite this, Mirtazapine had the two fold benefit of early appetite stimulation and, over the subsequent weeks, treating what in hindsight had been an underlying depressive episode.

A lesson to be learnt is that primary refusal to eat, even in the absence of overt depressive symptoms may indicate an occult depressive episode in this patient group. We have shown that Mirtazapine can be an effective treatment in such cases and can prevent distressing medical intervention from having to be used.

References

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P4-22
IS ELECTROCONVULSIVE THERAPY AN APPROACH FOR TREATING BALEFUL INSOMNIA?

Lead Author: Mahreen Raza, M.D.

Co-Author(s): Ye - Ming Sun, M.D.; Susan Zafarlofti, PhD

ABSTRACT:
Title: Is Electroconvulsive Therapy an Approach for Treating Baleful Insomnia?

Introduction: Treating refractory insomnia is a challenge. It has been known that electroconvulsive therapy (ECT) has improved sleep quantity and quality in depressed patients. However, ECT is seldom included in the treatment plan for baleful insomnia, partly because limited data is available for such as trial. The aim of this study was to examine the implementation and effectiveness of ECT for insomnia with actigraphy to monitor patient's vegetative changes during the course of ECT.

Methods: The patient is a 40 year old African American man who presented with insomnia, depression and suicidal thoughts. Failure of multiple medication trials led to the implementation of ECT. Consent for ECT was done. Patient agreed to take the actigraphy watch which was applied 2 days prior ECT and continued to be on through the acute phase of ECT. HAM-D scales were done before each ECT sessions.

Results: The post-intervention results showed significant improvements in self-reported and actigraphic sleep onset latency, and in self-reported sleep efficiency, sleep quality, and restedness. In addition, the perceived severity of insomnia, sleep-related dysfunctional cognitions, psychiatric and somatic symptoms, and the mental component of health-related quality of life improved significantly. The improvements lasted and strengthened over the follow-up period. It is interesting that significant improvement in sleep was happened earlier than other neurovegetative symptoms of depression detected by the HAMD scale.

Conclusion: ECT improved patient's sleep before mood changes and other neurovegetative symptoms. Thus it is possible that ECT improves insomnia which is independent of or leads to mood problem improvement. Additional work, however, is needed when interpreting the results.

P4-23
AUGMENTATION OF ANTIDEPRESSANT TREATMENT WITH LOW DOSE HYDROCORTISONE IN A PATIENT WITH BORDERLINE LOW CORTISOL: A UNIQUE CASE

Lead Author: Mahreen Raza, M.D.

Co-Author(s): Matthew Lin; Tobechukwu Clouden, M.D.

ABSTRACT:
Objectives: 1. Cortisol mobilizes and replenishes energy

stores while treating depression. 2. Medical causes should be taken into consideration while treating resistant symptoms of depression. 3. Borderline low cortisol can have significant impact on efficacy of depression treatments.

Method: Case presentation and literature review

Results: We describe a case of a 59 year old Caucasian man who was admitted to the inpatient psychiatric unit with a depressive episode of bipolar disorder. Upon presentation, patient endorsed recent alcohol abuse, hopelessness, suicidal ideations with plan of overdosing on pills, anhedonia, and fatigue. His symptoms resembled melancholia as the patient experienced a hyperactive stress response, anxiety, apprehension for the future, loss of responsiveness to the environment, insomnia, and loss of appetite. The depression was characterized by diurnal variation with depression at its worst in the morning. Refractory depressive symptoms despite titration of sertraline to maximum dosage led us to consult the Internal Medicine team. Due to concomitant orthostatic hypotension and dizziness he was tested for adrenal functioning. AM Cortisol came back borderline low at 3.3. Adrenal insufficiency was excluded due to normal response to the adrenal stimulation test. Morning salivary and serum cortisol levels remained low every day. The conclusion was made that the patient had borderline low cortisol. Patient was started on low-dose hydrocortisone as per Endocrinology consult. Patient responded relatively quickly to this treatment and his depression & fatigue greatly improved within 3 days with continued improvements noted on follow-up.

Conclusions: This is a valuable case from both clinical and educational points of view demonstrating the importance of knowing HPA axis physiology and the psychosomatic role of cortisol in relation to mood. Because the patient had primary adrenal insufficiency with no other HPA axis abnormalities, a direct relationship between borderline low cortisol levels and refractory depression is seen. Additionally, the known suppressing effect of alcohol use on adrenal function is demonstrated. Because fatigue, depression, alcoholism, sleep disturbance, and the age of the patient are factors that affect cortisol level, these variables should be taken into account in future investigations of refractory depression.

P4-24
HYPOTHESIZING THE CAUSATION LEADING TO CONVERSION DISORDER: DIFFERENCES IN SEX HAS SOME ROLE TO PLAY

Lead Author: Mahreen Raza, M.D.

Co-Author(s): Atika Zubera, M.D.; Magdalena Spariosu, M.D.; Diego Coira, M.D., Daniel Finch, M.D., Medical Students Trisha Sharma, .Nina Harkhani

ABSTRACT:
Objectives: 1-To learn and explore more data about gender differences, personality traits and psychosocial stressors as triggers or manifestations of conversion disorder which may have an impact on treatment, prognosis and outcomes of conversion disorder; 2-To explore the limited literature that is available on the presentation of conversion disorder in males versus females; 3-To understand the role of psychotherapy in addressing different underlying conflicts in patients with conversion disorder.

Methods: Case presentations and literature review

Results: We have studied two interesting cases of conversion disorder (CD) that we have encountered in Psychiatry CL service. The first case is of a 51 year old unemployed Caucasian male with dependent personality traits with a dominant spouse and the second case is of a 54 year old Hispanic female with avoidant personality traits and history of sexual abuse as a child. Patients with both sexes presented with psychogenic non epileptic seizures under periods of psychosocial stressors. In the literature review there is limited information about the underlying conflicts in different sexes and different personality traits serving as triggers in the manifestation of CD and through our case presentations we are suggesting that exploring those conflicts and the role of psychotherapy in addressing the conflicts might have an impact on the treatment, prognosis and outcome of CD.

Conclusions: Our cases suggest that there might be a link between the different sexes, their personality traits and underlying conflicts they have, in the manifestation of CD. Through more case studies, we hope to explore this link and to contribute further to this narrow field of research.

P4-25
PARITY AND THE PPACA: THE EVOLUTION AND ROLE OF THE HIX'S

Lead Author: Lawrence Richards, M.D.

ABSTRACT:
Parity in 3rd party payers as insurance coverage equality between physical and mental illnesses has not occurred despite passage of the Mental Health Parity and Addiction Equity Act in 2008; whether planned or accidental, the passage of the PPACAct in 2010 has resulted in Health Insurance Exchanges (HIX) in the several states essentially being the vehicle for parity. The HIX development accelerated with the June,2012 USSCt imprimatur of the PPACA as states line up for federal money. The determination of which are to be the essential benefits the health policies must offer in order to be listed on these HIX is crucial.

Author will outline the evolution of HIXs and their relationships to PPACA, HIT, and the 'other' hix, i.e. the Health Information Exchanges. Medical practice continues to become increasingly intertwined with economics and politics, which has non-political roots back to the BXBS policies of decades ago which essentially sold in-hospital coverage, thus expanding people's interest in care at the hospital; at least associated in time was the evolution of the demise of house calls and the expanding lab and procedural components of medical practice.

As examples of material to be presented the author offers the following. The economic motivations shown for policies listed on the HIX for individual purchase, as of now, will include subsidies some citizens get to buy Qualified Health Plans, leading to 47% price drops, while others may get 30% premium hikes. Legislative creativity is exemplified by N.C.'s proposed law--The Health Care Cost Reduction and Transparency Act--causing hospitals to post on the state's HIX cost information of the 50 most common episodes of care, which it is hoped will help residents understand their care via price breakdowns. This could reveal how efficient individual citizens could be in individually making decisions connected with regulating costs. Political manipulation is well represented within grants by HIX's to hire Navigators "to help" with QHP choices and eligibility applications! Also, budgetary alterations in Consumer Price Index (CPI) definitions will affect both payouts to beneficiaries and growth in tax brackets, altering the govt's costs without directly altering Medicare benefits! Inter-connectivity exists between the HIX's and states' expanding their Medicaid coverage, to wit a state with the 2nd smallest population receiving the 5th largest sum for its state HIX, resulting in its expectation its HIX will be 100% federally funded! [source, NEJM]

Since PPACA's major provisions do not become operative until 2014, this is as yet an evolving matter; while this is too late to affect a presidential election, other elections could be impacted. Over time medical organization have and will be "weighing in" as will various citizen organizations. The author will incorporate current updates of a bureaucratic, economic, medical, and political nature at the time of presentations.

P4-26
TELEPSYCHIATRY IN THE EMERGENCY DEPARTMENT: IMPROVING ACCESS AND INCREASING EFFICIENCY IN THE CARE OF PSYCHIATRIC PATIENTS

Lead Author: Rick Seidel, Ph.D.

Co-Author(s): Mark Kilgus, M.D., PhD

ABSTRACT:
Introduction: Throughout the United States, inpatient psychiatric beds have declined substantially, resulting in a dramatic increase in patients waiting to be evaluated and treated in emergency departments (ED). Carilion is no exception, and consequently added strain has been placed on the already taxed resources of Carilion's emergency department.

Telemedicine represents one method to offer timely services to these individuals, but the research has typically examined non-emergent patients. This study compared a psychiatrist performing an evaluation of an ED patient using telemedicine versus interviewing the patient face-to-face.

Methods: Subjects included 73 adult psychiatric patients admitted to the ED at Carilion who were being considered for discharge following a crisis evaluation. There were two conditions: 1) two psychiatrists went to the ED and interviewed the patient face to face, and 2) one psychiatrist went to the ED, while the other interviewed remotely via telemedicine. Only patients whose disposition was uncertain after an initial evaluation by a crisis worker were eligible for inclusion in the study.

The comparisons utilized one standardized evaluation tool for danger to self, the Scale for Suicide Ideation (SSI), and one for danger to others, the HCR-20. Psychiatrists also provided a diagnostic impression and disposition recommendation. Simple kappa was used to analyze nominal variables, weighted kappa for ordinal variables, and intraclass correlation coefficients for continuous variables.

Results: The average age was 39 years and the range was 18-74 years. 47 subjects were male and 26 female. Looking at the key variable of disposition determination, both groups demonstrated a high percentage of agreement. For the face-to-face arm, there was 84% agreement, and for the remote condition, 86%. Using kappa for the HCR-20, disposition recommendation, and diagnosis revealed no differences. ICC for the suicide scale also showed no differences.

Conclusions: As hypothesized, the confidence intervals between conditions overlap for all variables, indicating we did not find evidence of a difference in inter-rater reliability in the remote versus local conditions. Thus this investigation suggests that the conclusions drawn by psychiatrists interviewing patients in the emergency room are similar for both face-to-face and telepsychiatry interviews. However, the reliability of the ratings across all variables and across both conditions was typically in the fair to moderate range, and the confidence intervals around these estimates were wide. This outcome may have been due to the sample size, thereby indicating the value of replication with a larger sample. These findings do nevertheless offer preliminary evidence to support the use of telepsychiatry in emergent situations, a finding that could bring meaningful support to overtaxed emergency rooms, especially those in areas without readily available psychiatric services.

P4-27
EFFECT OF POSTTRAUMATIC STRESS DISORDER ON SLEEP ARCHITECTURE IN PATIENTS WITH OBSTRUCTIVE SLEEP APNEA

Lead Author: Edwin Simon, M.D.

Co-Author(s): Pinal Modi M.D., Hasnain Bawaadam M.D., Harpreet Sidhu, Amin Nadeem M.D., Asma Asif M.D., Irfan Waheed M.D., Adnan Khan M.D., Rashid Nadeem M.D.

ABSTRACT:
Objective: Both Obstructive sleep apnea (OSA) and Posttraumatic stress disorder (PTSD) are conditions individually associated with sleep disruption and sleep architectural abnormalities. Comorbid PTSD in OSA patients adversely affect treatment of OSA as reported by Hurwitz T et al. Recent studies have established the association between PTSD and OSA in terms of higher co-prevalence. However, the effects of PTSD on sleep architecture and sleep characteristics in OSA patients need to be further evaluated. Therefore we conducted a case control study.

Methods:

A retrospective chart review of all veterans diagnosed with OSA in past 3 years by polysomnography (PSG) studies was conducted. Individuals with OSA and PTSD were assigned to cases (OSA with PTSD, n=63) and similar number of consecutive charts selected as controls (OSA without PTSD, n=63). The demographic variables (age, gender), data from PSG studies; total sleep time (TST), sleep efficiency, Apnea-Hypopnea index (AHI), REM.AHI, sleep architecture (Percent of time spent in Stage I, Stage II, Stage III, Stage IV and REM sleep), Arousal Index, sleep and REM Onset, Periodic Limb Movement (PLM) Index (PLMI) and Arousal Index (PLMAI) registered. Documented medical diagnosis affecting sleep; gastro-esophageal reflux (GERD), benign prostatic hypertrophy (BPH), asthma and medications affecting random eye movement (REM) sleep were extracted from medical records. Linear regression analysis was performed to determine if there was a significant difference between the OSA with PTSD and OSA without PTSD groups for each of the sleep characteristics.

Results: There were no statistically significant difference between the two groups (OSA with PTSD and OSA without PTSD) for total sleep time (288.6±63.03 vs. 300±50.61, minutes p=0.26), sleep efficiency (77.53 ±26.31 vs. 78.36 ±12.26, % p=0.74), and OSA severity, as measured by AHI (28.63±15.79 vs. 25.94±19.73 p=0.40). Also no difference was noted for sleep architecture (% of time spent in stage I, stage II, or stage III/IV sleep), the arousal index (18.1±14.2 vs. 16.9±13.6, per hour p=0.62) and sleep onset, REM, PLMD and PLMAI (p>0.05). But the OSA with PTSD group had less REM sleep as a percentage of TST (11.49 ±7.83 vs. 15.03±7.52, % p=0.01).

Conclusion: Based on polysomnographic data no significant difference was observed in the sleep characteristics, OSA severity, arousal index and sleep architecture between the groups studied(OSA with and without PTSD) except that in OSA with PTSD group, less REM sleep was noted as a percentage of TST.

P4-28
THE EFFECT OF TIME TO TAKE ACETYLCHOLINESTERASE INHIBITORS ON SLEEP

Lead Author: Hoorim Song, M.D.

ABSTRACT:
Objectives: In pharmacopeia, it is written to take donepezil at night and galantamine at morning. Much of acetylcholine(Ach) in basal forebrain is released during REM sleep. However, increase of Ach is also associated with cortical arousal and up to 70% of patients with Alzheimer's disease experience disruption of nighttime sleep. We studied whether it would be different in sleep quality according to the time of taking medicine.

Methods: Ninety-two patients who had mild to moderate Alzheimer's disease (score between 1 and 2 on the CDR) and had taken donepezil (n = 54) or galantamine (n = 38) without antidepressants or sedative drugs were recruited between August 2012 and February 2013. Donepezil was oral soluble formulation and had been prescribed 10mg at night. Galantamine was prolonged release formulation and had been prescribed 8-24mg at morning.

We checked two kind of sleep visual analogue scale (VAS) for sleep quality during night and for daytime drowsiness. Subsequently, among donepezil group, 36 patients were changed the time of taking medicine to morning randomly (donepezil - AM group). Other 28 patients continued to take medicine at night (donepezil - HS group). Galantamine group was maintained taking medicine time in the morning. Eight weeks later, we checked sleep VAS again and compare the change.

Results: Both groups were not different in baseline characteristics. Both mean VAS for sleep quality and for daytime drowsiness in donepezil and galantamine group were significantly different (44.0 ± 26.4 versus 55.2 ± 27.3, p < .001; 38.8 ± 25.3 versus 48.8 ± 28.8, p < .001).

Then, the patients taking donepezil were randomly assigned to taking donepezil at morning group (n = 36) and at night group (n = 28). Eight weeks later, the significant changes of VAS were only in the donepezil at morning group (48.6 ± 25.7, p = .046 for sleep quality; 41.6 ± 28.3, p < .001 for daytime drowsiness).

Conclusions: This results suggest that taking acetylcholinesterase inhibitors in the morning can improve night sleep quality and daytime drowsiness. In cases of patients suffering sleep disturbance, changes of taking medicine time would rather be considered before adding sleeping medications.

Key words: Alzheimer, donepezil, galantamine, sleep

P4-29
DOES MIRTAZAPINE MAKE DIABETES WORSE IN DIABETIC PATIENTS?

Lead Author: Hoorim Song, M.D.

ABSTRACT:
Objectives: It has been known that mirtazapine could induce weight gain and be open to make diabetes worse. But in clinical situation, there are many instances where mirtazapine is prescribed for diabetic patients complaining insomnia and depression. This study aimed to assess that mirtazapine really have negative effects on diabetic process. To our knowledge, this is the first research about the influence of mirtazapine on diabetic profiles in the diabetic patients.

Methods: We searched 18 patients under the naturalistic diabetes treatments, who had been diagnosed as depression and prescribed mirtazapine at least for 6 months through the retrospective medical records review. Other 18 diabetic patients who had not taken any antidepressant were matched as a control group. BMI(body mass index), FPG(fasting plasma glucose), HbA1c were reviewed among baseline, 3 month and 6 month.

Results: Both groups were not different in baseline characteristics. Doses of mirtazapine are 15mg/day and 30mg/day. BMI has more increased in mirtazapine-treated group(p<0.05), but the changes of FPG and HbA1c were not different between both groups and they were not worsen under the naturalistic diabetic treatments. There were no differences in change according to doses of mirtazapine.

Conclusions: Mirtazapine can increase weight in diabetic patients. However, mirtazapine-induced weight gain was not linked with worsening of diabetic markers for 6 months. This results suggest that mirtazapine can be applied to diabetic patients suffering from depression with safety in case of they are stable state under the appropriate diabetic treatments.

Key words: mirtazapine, BMI, fasting glucose, HbA1c, diabetes

P4-30
MATHEMATICAL MODELING OF PALIPERIDONE PLASMA CONCENTRATIONS: A VISUAL GUIDE TO EXPECTED BLOOD LEVELS IN CLINICAL PRACTICE SCENARIOS

Lead Author: Larry Martinez, PhD

Co-Author(s): Peter Dorson, PharmD; Mahesh Samtani, PhD; Bart Remmerie, Chem. Eng; William H. Wilson, M.D.

SUMMARY:
Introduction: Mathematical pharmacokinetic (PK) modeling allows for the estimation of plasma drug levels in real-world scenarios. Previous modeling has been performed with risperidone long-acting injection to help clinicians understand the impact of dosing changes, missed or late doses, and treatment discontinuation (Wilson, J Psych Pract 2004). Paliperidone palmitate (PP), a once monthly, long acting injectable antipsychotic formulation, can be useful in patients with adherence problems. The formulation of PP is unique compared to other conventional depot antipsychotics and atypical long-acting antipsychotic agents. For example, there are half-life differences across the 5 available doses and it has an initiation dosage regimen that does not require oral antipsychotic overlap. The PK properties of PP as compared to orally administered paliperidone are discussed in the prescribing information but are challenging to understand without graphical representations.

Objective: Application of mathematical modeling of population based data for the development of an internet-based and an iPhone/iPad enabled tool that allows for the visualization of paliperidone plasma levels in real-world clinical scenarios of PP treatment including initiation, timing of injection, dosages, and site of injection.

Methods: Population based single dose PK data following PP administration were used to estimate and model plasma concentrations that can be expected in a typical patient in common clinical scenarios including during initiation and after longer term treatment, medication switching, and renal insufficiency. Modeling results were validated against the full PK models that were developed and published by Samtani (Samtani, et al. Clin Pharmacokinet 2009). Modeling outputs and findings were used to develop an internet-based application that can be used on a PC and an iPad/iPhone.

Results: Mathematical modeling was shown to effectively estimate paliperidone plasma drug concentrations under a variety of clinical PP treatment scenarios. An educational tool 'The Educational Dose Illustrator' was further developed as an interactive web-based tool (www.education-aldoseillustrator.com) that allows clinicians to visualize paliperidone plasma concentrations over time in order to gain an appreciation for how the unique PK properties of paliperidone palmitate produce predicable plasma drug levels that are resistant to fluctuations in the peaks and

troughs.

Discussion/Conclusions: The Educational Dose Illustrator (educationaldoseillustrator.com) provides an educational guide and allows clinicians to visualize estimated paliperidone plasma drug levels that may occur in real-world clinical scenarios such as missed treatment administration, changes in dose and/or timing, transition from orally administered paliperidone to injectable paliperidone palmitate, and in the case of medication switching, or in patients with renal insufficiency.

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P4-31
DELIRIUM, PSYCHOSIS, CATATONIA, AND MANIA: A CASE REPORT OF A YOUNG MAN WITH ANTI-NMDA-RECEPTOR ENCEPHALITIS WITHOUT TUMOR

Lead Author: Nicholas Tamoria, M.D.

Co-Author(s): Jonathan Wolf, M.D.

ABSTRACT:
Introduction: Anti-N-methyl-D-aspartate receptor encephalitis is a recently characterized auto-immune and paraneoplastic neurological disorder. Unknown prior to 2007, data suggests it is relatively common, occurring >4 times as frequently as HSV-1, VZV and WNV encephalitis. It presents with distinct psychiatric syndromes including delirium, psychosis, catatonia, and mania. Other symptoms include seizures, dyskinesias, aphasias, hypoventilation, and autonomic instability. Diagnosis requires specific testing for antibodies in serum and CSF not usually included in standard testing batteries. Female children and young adults are more frequently affected; occurring with and without tumor association (typically ovarian teratoma); and relapse may occur. Appropriate treatment includes behavioral control, immunotherapy, & tumor resection. Approximately 75% recover with mild sequela while 25% suffer severe disability or death.

Case: A 25 year old white male active duty US Sailor stationed in the Middle East presented to a local hospital with mutism, agitation, and disorientation. He was diagnosed with delirium tremens but did not respond to treatment. He was transferred to a US medical center where he was found to be psychotic with catatonic features including verbigeration, echolalia, echopraxia, and bizarre posturing. Olanzapine and lorazepam treatment were initiated. Brain MRI, EEG, and serum lab tests were normal but CSF was notable for pleocytosis without infectious etiology. He received one course of IVIG and IV methylprednisolone for presumed encephalitis. Specialized CSF analysis returned positive for anti-NMDA receptor antibodies. Malignancy workup was negative. He received 1 course of cyclophosphamide followed by 4 cycles of IV rituximab resulting in improvement of his symptoms and mental status. VEEG was negative. After finishing chemotherapy he developed a manic episode. He responded to divalproate and quetiapine treatment and eventually his mental status returned to baseline.

Discussion: It is important that psychiatrists are familiar with this disorder as the initial presentation invariably prompts early psychiatric evaluation. Dynamic symptom profiles often marked by agitation require ongoing psychiatric management. This case report highlights the disorder's multiple psychiatric presentations; the role of psychiatry in diagnosis and treatment; and the importance of a multi-disciplinary approach.

Conclusion: Anti-N-methyl-D-aspartate receptor encephalitis is a relatively new, prevalent, and lethal disorder which should be on the differential diagnosis in the psychiatric evaluation of a patient with dynamic psychiatric syndromes and supporting medical/neurological findings. A high index of suspicion, specialized lab testing, and multi-disciplinary approach are essential for appropriate treatment.

P4-32
THINKING OUTSIDE THE BOX: A SIMPLE BEHAVIORAL INTERVENTION FOR AN UNUSUAL CASE OF TRICHOTILLOMANIA

Lead Author: M. Pilar Trelles-Thorne, M.D.

Co-Author(s): Katerina Fineti, M.D.; Rashi Aggarwal, M.D.

ABSTRACT:
Introduction: Trichotillomania, an impulse control disorder, is a condition characterized by hair-pulling behavior. It can be accompanied by trichophagia, which in severe cases leads to formation of a trichobezoar and social and functional impairment. Trichotillomania has been found to affect as much as 4% of the population. Therapeutic interventions have proven to be limited. Cases of successful treatment with SSRI's, antipsychotics and mood stabilizers have been reported in the literature. Behavioral interventions appear to have a higher rate of remission. We present a case of trichotillomania involving pulling and eating hair from a synthetic wig, where a simple behavioral intervention dramatically improved the symptoms.

Methods and ***results:*** 41 year-old woman with a history of alopecia secondary to a chemical burn at age 13 presented to the emergency room with symptoms consistent with small bowel obstruction. She also had a history of trichotillomania and trichopagia involving hair from her wigs. A large trichobezoar, weighting 500gms, was extracted in the operating room. She was found to have co-morbid mayor depressive disorder. She was emaciated (BMI 16.5). Her post-operative recovery was complicated by multiple electrolyte deficiencies, related to chronic undernourishment, which led to a prolonged QTc of 550ms. She remained in the medical floor for one month, which allowed for daily visits by the psychiatry consultation liaison team. Her illness had produced significant functional impairment and social isolation. In consultation with the cardiology team and under cardiac monitoring, treatment with Sertraline 25mg PO daily was started. Her QTc prolonged to 650ms in the second day of treatment. Another trial with Aripiprazole 5mg PO daily caused QTc prolongation to 680ms in the third day of treatment. Behavioral approach was chosen instead. Patient wasn't able to identify anxiety prior or following hair pulling and eating behavior. She explained, on the contrary, felt relieved when in company of others, as she couldn't engage in the detrimental behavior. By actively engaging her family in treatment a plan to remove all wigs from patient was made. Family and patient participated in selecting alternatives to wigs for covering her alopecia. Patient started using colorful scarves. Six months after intervention patient remains asymptomatic. Her weight and affective symptoms had improved considerably as well.

Conclusions: This patient suffered from serious and debilitating consequences of trichotillomania. Her prognosis was worsened by multiple medical complications. However, one simple intervention- removal of wigs- led to recovery for this patient. As treatments are limited, treating psychiatrists have to think outside the box. The specific treatment that worked for our patient can't be recommended for everyone, but this case illustrates how in some instances a simple intervention can go a long way for a patient.

P4-33
THE INCIDENCE OF CONCUSSION PRESENTING AS DE NOVO OR WORSENING OF PSYCHIATRIC SYMPTOMS

Lead Author: Emily Williams, B.S.

Co-Author(s): Nolan Williams, Jeff Bodle, Jay Madey, Rebecca Lehman, Lee Lewis, Jonathan Edwards

ABSTRACT:
Category: Patient Oriented and Epidemiology

Introduction: Sports Concussion is a topic of very high interest in public opinion, and is frequently referred to in the media. Concussion is a complex pathophysiological process, induced by traumatic biomechanical forces and resulting in a graded set of clinical syndromes that may or may not involve loss of consciousness. Concussion can result in long-lasting effects on cognition as well as mood and affect regulation. While psychiatric symptoms have been demonstrated in athletes with prolonged post-concussive syndrome, the incidence and type of acute psychiatric presentations of concussion has never been described per our literature review.

Methods: We performed a retrospective chart review of 128 patients receiving immediate post-concussion care at our Sports Neurosciences Clinic. The charts were reviewed for presence or absence of any of the distinct psychiatric symptoms listed below.

Results: Of the 128 total subjects, there were 59 players with a psychiatric symptom as part of their immediate post-concussive symptom constellation. Sleep disturbance was the most common psychiatric presentation (26%). Other psychiatric presentations included: irritability (13%), mood lability (7%), increased emotionality (5%), sadness (4%), tearfulness (4%), personality change (6%), fatigue (6%), suicidal ideation (3%), impulsivity (2%), anxiety (2%), and affect change (2%).

Conclusion: Psychiatric complaints are a common presenting symptom of an acute concussive injury. Recognition of psychiatric sequelae is crucial for return to play decision making, as these are typically the symptoms that go unrecognized in the concussed athlete.

P4-34
A SOLDIER'S BATTLE FOR AUTONOMY

Lead Author: Christine Winter, D.O.

Co-Author(s): Harold Wain, Ph.D.

ABSTRACT:
Introduction: Medical decision making consults from medical and surgical teams are a common occurrence for psychiatry residents when serving on a consultation and liaison service. This requires the primary team to present an understandable picture of the illness and the available treatment options to all parties involved. The patient's then make their decision based on the information at hand. At times this is a difficult decision on personal, ethical and medical levels. The role of the consultant psychiatrist is to remain neutral, assist in the understanding of the information and to facilitate communication between the patient, the patient's family, and the primary team with the overarching goal of patient autonomy.

Background: Psychiatrists are frequently consulted for capacity evaluations in cases where a patient has had an abrupt alteration in their mental status and their ability to exercise their autonomy is questioned based on decisions that may be deleterious to their health. When a patient demonstrates understanding of their medical condition, treatment options, and the consequences of their decisions, they are considered to have medical decision-making capacity. At times, patient's autonomous decisions may collide

with the primary team's or family's agendas and impacts the dynamics of all involved in the care. Here we illustrate some common challenges with these evaluations especially when these cases involve young soldiers with severe combat related polytraumatic injuries.

Case: The patient is a 23 year-old white male, US Army soldier, with polytraumatic injuries resulting in severe complications requiring a series of amputations leading to bilateral hemipelvectomy. Due to life-threatening infection, he was recommended for hemicorpectomy. Psychiatric consultation was obtained after the soldier declined any further invasive treatments with the primary team's concern for depression and possible suicidality. The patient was determined to have full medical capacity and the support of his family for his decision despite the possibility of his demise. In this case the patient's decision had a positive outcome and several months later he continues to thrive.

Discussion: Some of the most common and difficult ethical issues to navigate arise when the patient's autonomous decision conflicts with the physician's beneficent duty to ensure the patient's best interests. Discussions have been fueled by medical ethics boards and patient rights advocates that continuously work to safeguard patient autonomy despite predicted untoward outcomes.

Conclusion: Every patient has the inherent right to autonomy within the American health care system while physicians have taken an oath to "do no harm" and will seek out a best possible outcome. The consultant psychiatrist will need to act as a patient advocate to ensure the medical treatment provided is based on sound decisions and maintains the patient's autonomy.

P4-35
THE RELATIONSHIP BETWEEN SOMATOFORM DISORDERS AND LIFE EVENTS IN DERMATOLOGY PATIENTS

Lead Author: Maymunah Yusuf Kadiri, M.B.B.S., FMCPsych

ABSTRACT:
Background: The skin as the primary organ of attachment in early life and as an organ of communication throughout the life cycle is especially 'vulnerable' to the development of somatization. When there is psychological trauma and or neglect during early life, the psychological consequences can be significant and overwhelming for the individual, and lead to dissociation and 'conversion' of the overwhelming emotional symptoms into somatic complaints referred to the skin (Gupta,2006).

Previously published studies have observed that life events or changes may constitute important stressors, and that they play a role in the onset of mental disorders, fibromyalgia and symptoms of joints and muscle disorders. (Brown and Harris 1978, Anderberg et al 2000).

This opinion is partly supported by research evidence, (Picardi and Abeni 2001) although not all studies give clearly positive results (Russiello et al 1995, Picardi et al 2003).

Objectives: To determine the pattern of somatoform disorders and life events in patients with skin diseases; To explore the relationship between somatoform disorder and life events in patients with skin diseases.

Methods: Between October and December, 2010, 400 participants attending the dermatology clinics of Lagos University Teaching Hospital were systematically selected. Informed consent was obtained from all participants. Sample size was calculated using 50% prevalence and 0.05 degree of accuracy. The symptoms checklist-90 (SCL-90) was used to assess psychopathological symptoms and the WHO Composite International Diagnostic Interview (CIDI), was used to diagnose somatoform disorders based on ICD-10 DCR. The Holmes and Rahe Life events scale was employed for the determination of life events at different time points. Data analyzed with SPSS.

Results: The commonest somatoform disorder was persistent somatoform pain disorder. Majority of patients were at slight risk of an illness for the life event scores. Figures 1 and 2 show that at one year and one month prevalence of somatoform disorders, a statistically significant proportion of participants with somatoform disorders were more likely to have experienced one form of life event or another ($p < 0.001$). Life events appeared to relate not only to the presence of somatoform disorders ($p < 0.001$), but also with the different types of skin diseases ($p = 0.008$).

Conclusion: The result obtained in this study is similar to previous research findings indicating that the higher the life event scores of patients, the more the likelihood of developing a somatoform disorder. There is a need for early specialist referral as well as an increase for more consultation liaison psychiatrists in all primary, secondary and tertiary health institutions in the country.

P4-36
PAROXETIN-INDUCED QTC PROLONGATION IN A PATIENT WITH TAKOTSUBO CARDIOMYOPATHY

Lead Author: Raman Marwaha, M.D.

Co-Author(s): Dr. Aasia Syed, M.D.; Dr. Rajasekhar Kannali, M.D.

ABSTRACT:
Introduction: Prolongation of the corrected QT interval (QTc) on the electrocardiogram is an important clinical condition because it increases the risk of polymorphic ventricular tachyarrhythmia called torsades de pointes , a medical emergency that can cause sudden cardiac death. QTc prolongation can be induced by many drugs including antipsychotics and tri cyclic antidepressants . Compared with tri cyclic antidepressants , selective serotonin reuptake inhibitors like paroxetine are less likely to cause severe cardiac side effects and have a high cardiovascular tolerability. In general , paroxetine is well tolerated in the overall patient population and the most common adverse effects of paroxetine include nausea , headache , dry mouth , sweating , somnolence , insomnia , constipation , tremor and sexual dysfunction .The purpose of this paper is to report an additional side effect of paroxetine.

Method: Case report. We present the case of a 47 year old woman with a history of stress induced cardiomyopathy, depression, and anxiety on paroxetine 60 mg daily who developed a QTc of 530 ms. Cardiology (Electrophysiology) was consulted, patient's electrolytes were normal and no other QTc prolonging factors were found . paroxetine was held , within 24 hours of discontinuing paroxetine electrocardiogram showed a QTc of 446 ms.

Discussion: In this case, we found a clear temporal relation between QTc prolongation and the use of paroxetine. paroxetine, like citalopram is known to exhibit QTc prolongation. While FDA has issued a warning that citalopram causes dose-dependent QTc prolongation , some cases of paroxetine induced QTc prolongation have also been reported in the literature.

Conclusion: Clinicians should be wary that paroxetine can cause QTc prolongation in patients with high risk profile. This case report also highlights the importance of routine examination of electrocardiogram and monitoring of QTc interval in patients receiving paroxetine. Clinicians should consider more frequent electrocardiogram monitoring in patients with high risk profile and electrolytes should be monitored as clinically indicated.

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P4-37
QUALITY OF ALCOHOL WITHDRAWAL TREATMENT: MONITORING SYMPTOMS AND VITAMIN SUPPLEMENTATION

Lead Author: Kasia Rothenberg, M.D.

Co-Author(s): Kasia Gustaw Rothenberg M.D., PhD; Christina Delos Reyes M.D.

ABSTRACT:
Supplementation with Thiamine and Folate in cases of alcohol withdrawal is considered evidenced based standard of care and should be implemented in order to correct depletion, promote recovery and prevent secondary pathologies. However, in the majority of versions of Electronic Medical Records (EMR), Alcohol withdrawal monitoring protocols, Clinical Institute Withdrawal Assessment (CIWA) is separated from vitamin order sets.

This IRB approved protocol presented here was designed as a quality improvement study.

The main objective was to assess the consistency of supplementation treatment of alcohol withdrawal to promote necessary changes.

The method included a collection of data regarding inpatient encounters to Cleveland's University Hospitals in a 6 months period during which alcohol withdrawal was included in patient care, statistically examining ratios of the CIWA order set being ordered in combination with Thiamine and/or Folate or without such vitamins.

Data obtained clearly indicated that vitamins would be usually ordered late if at all, in the course of the treatment.

Final statistical analysis suggested that routine standard of care for individuals in alcohol withdrawal may be improved by implementing EMR changes which would combine CIWA protocol with vitamin's orders sets.

P4-38
INTERVENTIONAL PSYCHIATRY: PLANNING FOR CORE COMPETENCY ACROSS THE PSYCHIATRY MILESTONE SPECTRUM

Lead Author: Nolan R. Williams, M.D.

Co-Author(s): Joseph J. Taylor, BS; Jonathan M. Snipes, M.D.; E. Baron Short M.D., MSCR; Edward M. Kantor, M.D.; Mark S. George M.D.

ABSTRACT:
Category: Curriculum Development and Education

Introduction: Interventional psychiatry is an emerging subspecialty at the interface of psychiatry and neurology that utilizes a variety of neuromodulation techniques in the context of an electrocircuit-based view of mental dysfunction as a major proximal contributor to refractory psychiatric illness. Currently, the general psychiatry residency predominantly focuses on teaching residents a variety of psychotherapies and psychopharmacology, yet has few standard expectations related to ECT and none related to interventional techniques such as deep brain stimulation (DBS) or neuroimaging. We propose the development of an interventional psychiatry training paradigm analogous to those found in cardiology and neurology. Comprehensive training in interventional psychiatry would include didactics in the theory, proposed mechanisms, and delivery of invasive and non-invasive brain stimulation. The development and refinement of this subspecialty area of psychiatry would facilitate safer, and better ensure effective, patient-centered growth in the field of brain stimulation by more consistent training and eventually certified and credentialed practitioners within the field. This attention and coordination will help drive the efficacy of treatments along with advances in clinical research.

Practice Gap: Emerging interventional psychiatric techniques, such as Transcranial Magnetic Stimulation (rTMS), Deep Brain Stimulation (DBS) and refined ECT strategies, will require a more standardized approach, including minimum expectations reflecting competency in regard to predetermined milestones, appropriate to training for the next generation of psychiatric practitioners and scientists. As there has been an exponential rise in the utilization of interventional psychiatric techniques over the last 10 years this, along with social, political and technical factors, has contributed to a further widening of the practice gap in the field. We present the evolving interventional psychiatry landscape, and propose strategies for integrating interventional psychiatric knowledge and propose core competencies, across various stages of psychiatric education, all in line with the evolving milestone movement and increasing oversight in medical education and maintenance of certification.

Educational Solution: We suggest that interventional psychiatry be introduced into training at three levels: (1) a core curriculum of knowledge and experience during psychiatry residency training, (2) well-defined, non-invasive neuromodulation track as a more advanced elective component of psychiatry residency training, and (3) a more formal post graduate interventional psychiatry fellowship. We hope to introduce the paradigm of an interventional psychiatric practitioner and propose a phased plan for integration of interventional psychiatric techniques, didactics and minimum competencies into psychiatric education.

P4-39
HOMELESSNESS AND SECONDARY TRAUMA: A MINDFULNESS MEDITATION-BASED PILOT CURRICULUM TO HELP STAFF COPE

Lead Author: Anna Huh, B.A., B.S.

ABSTRACT:
Background: Those working in and amongst homeless and transient populations often experience varying degrees of secondary trauma as a result of daily exposure to the stories and experiences of those living in unstable situations. This phenomenon may lead to high levels of stress and burnout among professionals working closely with homeless populations, and additionally affect performance over the long term. This poster will present the results of a mindfulness-based intervention to reduce stress among professionals working in a homeless shelter in a rural community in White River Junction, Vermont.

Design: Pre- and post-intervention comparison

Intervention: A curriculum was designed based on the principles and practice of mindfulness-based stress reduction. The curriculum was delivered twice a week over six weeks, with each session lasting 60 minutes.

Setting: The Upper Valley Haven, a homeless shelter in the rural community of White River Junction, Vermont.

Measures: Both quantitative and qualitative data were collected. Quantitative measures include pre- and post-intervention measures of stress and self-efficacy. Qualitative measures included post-course questionnaires with directed questions and open comments.

Results: Currently in analysis.

P4-40
ACUTE ONSET PSYCHOSIS IN A PATIENT WITH TEMPORAL LOBE EPILEPSY

Lead Author: Marc Anthony Bouchard, D.O.

Co-Author(s): Jonathan Wolf, M.D.

SUMMARY:
Introduction: The differential of acute mental status changes is broad, to include neurologic, substance related, infectious, and primary psychiatric etiologies. Diagnosis in cases of Altered Mental Status (AMS) requires medical evaluation in addition to consideration of primary psychiatric disorders. Taking a careful and detailed history becomes even more essential in cases where a medical cause of the psychiatric presentation is suspected. This is a case of a patient whom presented with acute mental status changes and marked paranoia ultimately found to have left temporal lobe epilepsy after spontaneous resolution of mental status changes and paranoid thinking.

Case: The patient is a 45 year-old male retired soldier with a history of one previous episode of acute onset of paranoia and AMS during deployment to Iraq three years prior to presentation that spontaneously remitted, who was admitted to the medical service for acute mental status changes, disorganized behavior, and paranoid thinking. A complete medical workup was performed to include laboratory for AMS, head imaging, and CSF studies, all of which did not reveal a clear etiology to explain the patient's presentation. Ten days after admission the patient was noted to no longer be demonstrating disorganized behavior, his previous paranoid thinking was largely resolved, and he began demonstrating insight into the behavioral abnormalities he was exhibiting. He received a single one-time dose of 2mg IM lorazepam and 0.5mg risperidone for an episode of acute agitation and paranoia two days after admission, and was noted to demonstrate marked improvement upon clinical exam nearly immediately afterwards. A 48-hour video EEG was performed later in the hospitalization which revealed slowing and epileptiform discharges in the left temporal region. The patient was started on lamotrigine 25mg daily and discharged without out-patient neurology follow-up. He has since been titrated up to lamotrigine 200mg daily without any further complications.

Discussion: In patients whom present with AMS it is important to conduct a thorough medical workup prior to diagnosing a primary psychiatric disorder. Temporal lobe epilepsy (TLE) is a known clinical entity that causes a post-ictal psychosis (PIP) in up to 9% of patients with TLE. Common presenting features include disorganized behavior, delirium, auditory or visual hallucinations, and paranoia. PIP accounts for up to 25% of all psychotic presentations of patient's with epilepsy, and as much as 50-60% of patients with a history of PIP can suffer additional episodes. This case illustrates a common presentation of PIP in a patient with TLE whom manifested an acute onset of disorganized behavior and paranoid thinking.

P4-41
WHAT ARE THE INGREDIENTS TO COMPASSION FATIGUE? A SYSTEMATIC REVIEW

Lead Author: Connie Barko, M.D.

Co-Author(s): Robert Perito, MD

SUMMARY:
Introduction: The concept of compassion fatigue has continued to evolve since its inception to encompass emotional exhaustion experienced by healthcare providers. A more recent understanding of compassion fatigue is a constellation of symptoms that results from working and identifying with critically ill patients and vicariously living through the victims' experiences. In the light of increased burden of trauma victims from current military combat operations, we attempted a descriptive systematic review of the current literature to better elucidate different factors that impact compassion fatigue.

Methods: Using Medline database, we searched keywords "compassion fatigue," "compassion satisfaction," or "countertransference," and "physician." We filtered for full text articles published from 2007 to present.

Results: The database yielded fifty-nine articles, with secondary review for relevant content yielding thirteen articles. Literature showed increased compassion fatigue in healthcare providers who regularly interact with critically ill and dying patients. These included intensive care and cancer nurses, surgeons, pediatric palliative care, emergency medicine physicians, and providers who worked with disaster victims. Two articles addressed factors surrounding compassion fatigue in the military. Several factors were noted to shape compassion fatigue including the length of exposure, level of empathy, coping skills, resiliency, operating under demanding conditions, and dissatisfaction with one's career. This was shown to manifest in physiologic, cognitive, and interpersonal symptoms. In contrast, protective factors included providers who had a unified concept of self, balanced perception of work versus personal life, and experienced integrated deaths early in life that were normalized and dealt with openly.

Discussion: Our research identified several predisposing and perpetuating factors. The overall theme suggested that it is more likely to occur in response to the duration and intensity of exposure in the absence of protective factors. These protective factors were identified and surrounded the concept of self. A noteworthy observation from this research suggests that exacerbating factors may be reduced and protective factors could potentially be enhanced. These would suggest that a systemic resiliency program could have the potential of reducing provider's compassion fatigue.

Conclusions: Compassion fatigue is more prevalent among health care providers who regularly work with critically ill patients. It has the potential to lead to burnout, impacting patient care. Personal, professional, and organizational strategies can be put in place to normalize death and dying, increase caregiver resiliency, and enhance coping mechanisms. Further research could investigate how compassion fatigue has impacted military physicians, who have had increased load of trauma patients since the beginning of current war campaigns.

P4-42
DUAL AGENCY IN THE MILITARY: MITIGATING THE INFLUENCE OF A THIRD PARTY IN THE THERAPEUTIC DYAD

Lead Author: Adam Lee Hunzeker, M.D.

Co-Author(s): William Rumbaugh, M.D.; Vincent Capaldi, M.D.

ABSTRACT:
Background: Dual agency is a vital ethical consideration in modern military medicine. The primary ethical underpinnings of beneficence, autonomy, non-maleficence, and justice are predicated on the assumption that our patients are our primary focus. Complications occur when the interests of a third party interfere in the physician-patient dyad. For decades the preponderance of literature about dual agency was focused on the military. This unique clinical environment is considered a danger zone for providers due to the proclivity for dual agency and boundary violations. Military psychiatrists must balance the needs of the organization to maintain combat fitness for austere environments while providing care and reducing barriers to care. The daily challenges military psychiatrists face as a dual agent are illustrated in the case below.

Case: 23 year old enlisted sailor with diagnosis of borderline personality disorder, post traumatic stress disorder, and depression with one hospitalization for suicidal ideation seen for exacerbation of symptoms in the context of legal stressors. The patient's legal charges stemmed from military misconduct resulting in a pending courts martial and significant conflict with her command. Both command and patient were at odds regarding the necessity and effect of a medical board evaluation (MEB) for fitness for duty and possible medical retirement.

Discussion: The case depicts the duality of a military provider. There is clearly a third party involving itself in the therapeutic dyad with its own agenda creating a conflict of interest. Initiation of a medical board would likely serve as a mitigating factor in the case and assist the patient financially if discharged. Initiating a time consuming process of a medical board would also delay her departure from the military for more than a year perpetuating her current malignant environment. This would also deprive the parent unit of a replacement service member, impacting the unit's mission readiness. The duty of the psychiatrist to the commander is codified in military law and specific in nature. On the other hand, the responsibility of the psychiatrist is governed by many principles including the Hippocratic Oath. We will highlight the specific legal obligations of a military psychiatrist as a dual agent, and then recommend guiding principles to navigate these daily scenarios. Awareness of these are important outside the military system as millions of veterans seeking care in the community have perceptions of psychiatry colored in the military environment. Additionally, our civilian colleagues are beginning to face similar challenges with the implementation of managed care models that are subjected to increased scrutiny over efficiency and cost.

Conclusion: Awareness and insight into the impact of dual agency in the military model is essential. Learning to balance these demands is valuable for providers both in the military and civilian settings.

P4-43
LOW THYROID STUIMULATING HORMONE LEVELS IN ACUTE GEROPSYCHIATRIC ADMISSION AND IMPROVEMENT WITH RESOLUTION OF PSYCHOSIS

Lead Author: Diana Goia MD

Co-Author(s): Subramoniam Madhusoodanan, M.D.

SUMMARY:
Introduction/Hypothesis: thyroid function abnormalities are not uncommon in acute psychiatric admissions in adults and adolescents. However there is paucity of published data in acute geropsychiatric patients. A seventy five year old African American man with Alzheimer's dementia was admitted with symptoms of agitation, aggression and delusional behavior. Patient had no history of thyroid disorder. The thyroid stimulating hormone (TSH) level was low at 0.235 mIU/ml. Other thyroid workup was negative. We suspected that the TSH abnormalities were possibly related to the acute psychosis.

Methods: Serial measurements of TSH every 5 days and concomitant assessment of treatment progress with clinical global impression scale (CGI), severity and improvement scores were done.

Results: TSH levels improved from an admission low of 0.235 to 0.346 after 5 days and 0.510 after 10 days. The CGI score severity was 6 on admission (baseline) and 1 at discharge (endpoint). The CGI improvement score was 2 at midpoint and 1 at discharge (end point).

Conclusion/Discussion: Improvement in TSH levels corresponded with improvement in the psychosis, as evidenced by the CGI scale changes. Of the various thyroid function abnormalities in acute psychosis, TSH changes are less common. Elevated triiodothyronine uptake (T3 uptake) is more common. Thyroid work-up and follow-up thyroid functions in 2 weeks are recommended before treatment options are considered for thyroid function abnormalities in acute psychotic patients.

P4-44
RAPID RESOLUTION OF DEPRESSIVE SYMPTOMS WITH METHYL PHENIDATE AUGMENTATION OF ANTIDEPRESSANT IN AN ELDERLY DEPRESSED HOSPITALIZED PATIENT

Lead Author: Diana Goia MD

Co-Author(s): Subramoniam Madhusoodanan, M.D.

SUMMARY:
Introduction/Hypothesis: Elderly depressed patients with multiple comorbidities pose a significant challenge in treatment due to the pharmacokinetic and pharmacodynamic changes and the fragility of their physical conditions. Presence of suicidal tendencies, poor eating pattern, delayed therapeutic action of all antidepressant drugs and partial or no response to antidepressants further complicate the management of depression in elderly patients. In a hospital environment, the pressure from managed care companies and length of stay considerations call for strategies which reduce the hospital stay. We report an elderly patient admitted with severe depression and poor eating pattern who improved rapidly with augmentation treatment of the antidepressant with methylphenidate.

Methods: A 72 year old man with no previous psychiatric hospitalization, but recent psychiatric care in the nursing home was admitted because he was refusing to eat or open his mouth for a week prior to admission. He also was paranoid and jealous about his wife. He was depressed and had impaired memory. He was not suicidal or homicidal. He had history of depression, dementia, diabetes mellitus, gastro esophageal reflux disease, glaucoma, hypertension, megacolon, and quadriplegia secondary to spinal cord injury. His diagnosis on admission was dementia Alzheimer's type with depressive and delusional symptoms. Patient was on mirtazapine 30 mg po hs on admission on 7/28/12. He was started on risperidone 0.5 mg PO daily and titrated up to 2.5 mg daily by 8/7 in view of continuing psychotic symptoms. Patient's mood was labile and he was eating and communicating poorly. On 8/3/12, methylphenidate 0.5 mg was added in in view of poor eating pattern and communication and depressive symptoms. Patients's eating pattern and communication improved over the next 7-10 days and patient was discharged on 8/13/12. Clinical status was assessed by Clinical Global Impression (CGI) scale.

Results: CGI-S score on admission (baseline) was 6. At midpoint (1 week after admission) CGI-S score was 6 when methyl phenidate 5 mg was added. CGI-I at this time was 3. At end point (discharge) a little over 2 weeks after admission CGI-S was 1 and CGI-I also 1. Patient tolerated the methyl phenidate augmentation without any significant side effects.

Conclusion/Discussion: Our patient showed significant improvement justifying discharge in about 2 weeks of admission. Previous open label studies of methyl phenidate augmentation in elderly out patients showed improvements by week 8 and a small controlled study showed improvement by week 3. Methyl phenidate augmentation may be helpful in elderly depressed patients for clinical improvement, reducing morbidity and duration of length of hospital stay. Further controlled studies are recommended.

SATURDAY, OCTOBER 12, 2013

POSTER SESSION 5

P5-01
BENEFITS MANAGEMENT FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

Lead Author: Karen Ablondi, M.P.H., M.S.W., CADC-II

Co-Author(s): Serowik, K.L.; Rosen, M.I.

ABSTRACT:
Psychiatric disabilities are frequently accompanied by mental status changes and co morbid illnesses that complicate management of SSI and SSDI payments. Beneficiaries who mismanage their funds are at particularly high risk for homelessness, substance abuse, and treatment non-compliance. When properly implemented, payee assignment is associated with improved treatment compliance, better money management and other clinical benefits. This study assessed the effectiveness of a brief intervention (Benefits Management) that sought to identify individuals who might need a representative payee, counsel them about payeeship and find a payee (when appropriate). Participants enrolled were SSI/SSDI beneficiaries in acute psychiatric care who were at risk for needing a payee because of recent homelessness and/or hospitalization. Altogether, 37 participants were randomly assigned to an Illness Management control condition and 37 to Benefits Management. Participants were encouraged to meet with study therapists at least four times over the course of 6 months and complete data collection assessments at weeks 4, 8, 12 and 24. There was no significant difference between the groups over time on the primary a priori outcome measure, the Heinrich-Carpenter Quality of Life Scale. Despite many participants' having considerable money management difficulties, none of the participants assigned to Benefits Management were assigned a representative payee as a result of their study participation. Data will be presented regarding Benefits Management's acceptability to participants, and participants' perceptions of the therapy. Benefits Management appeared to have little impact on participants' clinical course. Issues that arise in negotiation of payee assignment with SSI/SSDI beneficiaries will be presented.

P5-02
THE IMPACT OF INTERNALIZED STIGMA, PATIENT

ACTIVATION, AND AUTONOMY PREFERENCE ON ILLNESS SELF-MANAGEMENT AND INTENSIVE SERVICE USE IN SCHIZOPHRENIA

Lead Author: Erin L Adams, B.A.

Co-Author(s): Michelle P. Salyers, PhD

ABSTRACT:
Background: Fear of stigmatization has been shown to discourage individuals from seeking mental health treatment and adhering to treatment regimens. Internalized stigma (self-stigma) is the damage done to an individual's self-esteem and self-concept when one applies public stigma of the mentally ill (such as being untrustworthy or incompetent) to oneself. We tested a editational model to examine how self-stigma may influence high intensity service use in the form of hospitalizations and emergency room (ER) visits. We proposed that self-stigma may lead people to be less activated and autonomous in treatment decisions, which could lead to poorer self-management and ultimately more emergency and hospital-based care. Autonomy preferences and patient activation have been linked to improved self-management behaviors and health care outcomes in general health populations, but less work has been done in psychiatric samples.

Methods: We conducted a secondary analysis of data from a randomized controlled trial of an Illness Management and Recovery Program (n=118). Survey data was collected at baseline and 9 month follow up. Data on psychiatric ER use and number and length of hospitalizations were obtained from medical records for the 12 months prior to the study through 9 month follow up. Measured variable path analysis was used to analyze the proposed model, described above. Additional exploratory regressions were conducted to further define the relationships between these constructs.

Results: The model explains an acceptable amount of the variance in predicting ER use (Chi-square = 11.55, df=9, p=.239, RMSEA=.049, 95% CI=0-.12). Results indicate that the relationship between self-stigma and illness self-management at baseline was fully mediated by activation (but not autonomy preference) at baseline, and that illness management predicted frequency of psychiatric ER use at 9 months (r2=-0.19, p<.05). Models for hospitalization frequency or length of stay were not supported.

Discussion: This model indicates that self-stigma may lead to reduced activation, which can impact the level of illness self-management and subsequent psychiatric ER use. Interventions designed to reduce self-stigma and enhance activation may thus be able to improve self-management and reduce emergency service use, improving patient outcomes and reducing health care expenses.

P5-03
NEEDS OF PATIENTS WITH SEVERE MENTAL ILLNESS AFTER 20 YEARS OF THE PSYCHIATRIC CARE REFORM IN SANTOS, BRAZIL

Lead Author: Sergio Baxter Andreoli, Ph.D.

Co-Author(s): Andrade, M.C.R.; Cacozzi, A.; Peluffo, M.P.; Oliveira, P.R.N.; Martin, D.

ABSTRACT:
One of the first experiences of psychiatric care reform occurred in the Brazil was in the city of Santos, southeastern Brazil. Over the past 20 years, the network of mental health care was structured in community services (1.2 per 100,000 inhabitants.). It is evenly distributed around the city and attend to all psychiatric disorders, but the most frequent being those considered serious.

Objective: To study the needs of patients with a diagnosis of schizophrenic disorder and other psychotic disorders in the Santos psychiatric care network.

Method: A cross-sectional study on a probabilistic sample of 401 patients seen in all 5 psychiatric care service community of the city of Santos in the one-year period preceding the survey. The instruments used were: Composite International Diagnostic Interview, Life Chart Rating Form, Positive and Negative Symptom Scale – PANSS. The needs were assessed by Camberwell Assessment of Need (CAN) in direct interviews with patients.

Results: Fifty seven (57%) were single; mostly men, and 14.5% were working in the last 6 months. Sixty seven (67%) had been hospitalized in life, 15.5% in the last year, 91% were in treatment, 84% used the service last month and 30% with more than one contact. Pharmaceutical care and psychiatric consultation were the most commonly used treatment modalities, 97% and 88.7%. Ninety (90%) were taking neuroleptics (77.5% typical and atypical 12.5%) and 77.7% were satisfied, with no difference between the type of medication. At the last year, 8.5% attempted suicide, and 9.5% severe. The positive symptoms more frequent were delirium (9%) and conceptual disorganization (10%). Among the negatives symptoms were the difficulty in abstract thinking (34%), social withdrawal (21%) and emotional withdrawal (16.5%). Among the symptoms of general psychopathology the most frequent were active social avoidance (21%), and critical judgment (14.6%) and depression (12.8%). Patients reported that their greatest needs were related to psychotic symptoms (67%), information (56%) and psychological distress (43%). ***Conclusion:*** The network of mental health care presenting positive indicators, such as the easy access to services and medications. However, our study showed high prevalence of negative symptoms and needs related with the control of psychotic symptoms. These results may be useful

for the organization of care to patients with severe mental disorder. Greater attention should be given to adjustments of medication and psychological support.

P5-04
INCORPORATING RECOVERY IN ACTION FOR PSYCHIATRY RESIDENCY CURRICULUM

Lead Author: Ali Abbas Asghar-Ali, M.D.

Co-Author(s): Dr. Ali Abbas Asghar-Ali, Dr. Joshua Thomas

ABSTRACT:
The most recent Substance Abuse and Mental Health Services Administration definition of recovery describes it as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The theme for the APA Annual Meeting in 2013, "Pursuing Wellness across the Lifespan" also underscores a recovery principle by placing the focus on "wellness" rather than "illness." Despite such widespread acceptance and endorsement of recovery perspectives, recovery oriented care has not been incorporated into most academic curricula or health care missions. This poster will outline curricula for teaching recovery oriented practices to psychiatry residents, integrating didactics and clinical rotations. Data supporting use of recovery education on an inpatient service will be presented.In 1961 the United States Joint Commission on Mental Illness and Health stated that, "the objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner." Since then, the American with Disabilities Act in 1990, the Surgeon General: Report on Mental Health (1999), and the New Freedom Commission on Mental Health in 2003 reiterated a focus on recovery oriented care. The most recent Substance Abuse and Mental Health Services Administration definition of recovery describes it as, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Despite such widespread acceptance and endorsement of recovery perspectives, education about recovery oriented care has not been incorporated into most academic curricula. To address this need, a curriculum for recovery oriented practices was instituted at Baylor College of Medicine, Menninger Department of Psychiatry. In addition to a series of didactic sessions, residents received a four week curriculum during their inpatient rotation. The curriculum included a pre- and post-survey (recovery knowledge inventory), pre-reading, demonstration of recovery based interviews, and at the conclusion of the rotation, performance of a recovery based interview by the resident. Supervision was provided by a psychiatrist and psychologist. Results of the recovery knowledge inventory showed substantial improvement in a variety of domains. Based on preliminary results, the proposed rotation curriculum provides a mechanism of increasing residents' knowledge and practice of recovery based principles and may serve as a model for training at other institutions.

P5-05
ASSERTIVE COMMUNITY TREATMENT: FACTORS CONTRIBUTING TO THERAPEUTIC SUCCESS

Lead Author: Charles Beasley, M.D.

Co-Author(s): Sun Young An, CRC, Elena Bruck, M.D., Michael Serby, M.D.

ABSTRACT:
Background: Assertive Community Treatment (ACT) programs offer community based treatments to chronic severely mentally ill patients. The ACT program at Beth Israel Medical center has consistently demonstrated decreases in utilization of resources as manifest by fewer hospitalizations and ED visits. We explored factors that may underlie this success, including alliance with treatment team, substance abuse, use of decanoate antipsychotics, and AOT mandated care.

Methods: A chart review was done for all Beth Israel ACT patients who had been under care for >6 months to determine the number of ED visits and hospitalizations in the 6 month period before and after admission to ACT. Substance abuse history, AOT mandated status to the ACT team, and use of decanoate antipsychotics at time of admission as well as the number of failed outreach attempts in the first 6 months of care were also recorded. Number of failed outreach attempts was presumed to be a reasonably good and quantifiable measure of alliance with ACT team. Overall patient improvement was measured based on decrease in psychiatric ED visits, psychiatric Inpatient hospitalizations and total encounters (ED visits + inpatient admissions) in first 6 months of act care as compared to the 6 months prior to admission to ACT team.

Results: 1. OVERALL: High utilization group at baseline (defined as those with >2 total encounters [ED + inpatient] in 6 months prior to ACT admission) showed comparable percentage reduction (35% vs. 34%) in total encounters from 6 months pre- to 6 monts post-ACT admission, as compared with low utilization group The high baseline utilization group showed no significant difference in failed outreach attempts as compared to low utilization group

2. AOT: For the patient census as a whole, no significant difference was present in utilization reduction or alliance between AOT and non-AOT.

3. DECANOATE: For the entire patient census, those patients not on decanoate antipsychotics had significantly

greater percentage decrease in total encounters 69% v. 43%

4. SUBSTANCE ABUSE: For the entire patient census taken together, substance abusers show strong trend trend towards more failed outreaches.

Conclusions: Our results suggest that ACT is beneficial for severely and persitantly mentally ill patients independent of severity of illness. It is unclear why patients who are not on decanoate antipsychotics appear to demonstrate greater improvement under assertive community treatment than those on decanoate. This may be a testament to the overall strength of the ACT model which may encourage better alliance. Though not necessarily more likely to be rehospitalized, substance abusers are more likely to miss scheduled visits and thus seemed to have poorer alliance and furthermore this was the solitary factor that seemed to have an impact on alliance.

P5-06
REASONS FOR PSYCHIATRIC VISITS: AN ANALYSIS OF CONSUMER AND PSYCHIATRIST AGREEMENT

Lead Author: Kelsey A. Bonfils, B.S.

Co-Author(s): Erin L. Adams, BA; Heidi M. Hedrick, MS; Michelle P. Salyers, PhD

ABSTRACT:
Background: Shared decision making is a burgeoning area of research in psychiatric consultations, but little has been done to understand the level of agreement between consumers and providers. We examined the primary reason for the visit to better understand the level and predictors of agreement between consumers and providers.

Methods: Data was obtained during baseline interviews in a study of CommonGround, an intervention designed to increase shared decision making. Participants were recruited from two outpatient clinics and two Assertive Community Treatment (ACT) teams within one community mental health center (N = 168). Participants had a mean age of 44.1 and were predominantly African American (54.8%) and male (56.9%). After each appointment, consumers and providers were independently asked to provide the reason for the visit. We developed a codebook of 21 categories, which were then applied to the reasons for the visits. We also matched provider and consumer reasons and rated them as no agreement, partial agreement, or full agreement. We examined frequencies for each of the reason categories and level of consumer/provider percent agreement. Analysis of variance (ANOVA) was utilized to explore the relationship between coder-rated level of agreement and provider and consumer characteristics.

Results: Percent agreement was 90% or above for 16 of 21 categories; overall agreement for each category ranged from 66.4% to 99.4%. The most frequently cited reason by providers was "symptoms" (N = 48; 28.9%); for consumers, it was "medication" (N = 56, 33.7%). Coder-rated consumer/provider agreement most often indicated no agreement (N = 82; 50.0%), with only 19.6% (N = 33) of responses indicating full agreement between consumer and provider. The four providers differed significantly in their levels of agreement, X2(6) = 25.0, p < .001, suggesting individual prescriber variation. More generally, outpatient providers tended to have better agreement with consumers than did ACT providers, X2(2) = 8.1, p = .018. Consumer age approached significance (F(2, 160) = 2.97, p = .054); post-hoc tests revealed consumers in full agreement with providers were older (M = 46.8) than those in partial agreement (M = 41.4) (p = .052). No significant relationships were found between level of consumer/provider agreement and consumer scores of patient activation, trust in provider, or perception of provider patient-centeredness.

Conclusions: We found half of our psychiatric consultations to have no agreement on the reason for the visit between providers and consumers. Providers in community mental health centers need to work toward developing a common language with consumers to ensure that consumer goals for psychiatric visits are acknowledged and achieved.

P5-07
THE ROLE OF COGNITION AND SYMPTOMS IN SCHIZOPHRENIA ASSESSMENT AND TREATMENT

Lead Author: Brian Brotzman, B.A., M.A.

ABSTRACT:
Background: Clinical improvement (CI) is a term denoting a positive change in symptom presentation, symptom severity, and level of function. CI in schizophrenia has been regarded as an indicator of overall improvement in the clinical milieu and is often described as outcome (FO). CI is assessed primarily by clinical impression and judgment. Additionally, clinical trials and inpatient stays evaluate improvement by measuring change in CI. Evidence suggests that cognitive factors and negative symptoms are better predictors of FO than positive symptoms. Yet, focus of treatment and assessment appears to rely largely on positive symptoms. This study sought to distinguish a discrepancy between what informs clinical judgment, and if judgment is truly representative of improvement.

Methods: Fifty-three schizophrenia inpatients treated with a standardized protocol of an anti-psychotic medication were assessed on symptom presentation (BPRS) and cognitive measures at baseline and 6 month follow up or at discharge to determine which factors predict judgment, and how those factors translate to CI. Cognitive scores were factored into components of focused attention, verbal recall, response time, decision making, and memory. Positive and negative symptom subscales were derived from the BPRS. Cognitive factors and symptom subscales were used to predict clinical improvement based on BPRS equivalent CGI score. This model was applied to time 1, time 2, and to the observed change between times.

Results: Positive symptoms only were predictive of judgment for clinical global assessment in all analyses (R2=.41 F(8,41)=3.53 p <.01, B=.15 S.E.=.03 ?=.7 p < .01) . Positive symptoms (Odds ratio (OR) = 1.19 C.I. = 1.00, 1.42) and negative symptoms (OR = 1.32 C.I. = 1.04, 1.68) significantly predicted CI at baseline (?2 (2) =7.53 p = 0.02). At 6 month follow up/discharge only positive symptoms (OR =.83 C.I. = .70, 1.00) were predictive of CI (?2 (1) =4.72 p = 0.03). Based on observed change, only change in negative symptoms (OR=1.88 C.I. = 1.01, 3.51) significantly predicted CI (?2 (8) =22.69 p < 0.01).

Conclusion: Although cognitive factors have been reported to account for up to 50% of the variance in FO, they are generally not considered in routine clinical assessment. Additionally, it appears negative symptoms determine CI when observing the change in clinical care. Despite this fact clinical impressions and treatment remain predominantly informed by positive symptoms. Our focus for assessment and treatment may require a greater consideration of negative symptoms and cognition.

P5-08
PARADOXICAL REACTIONS TO BENZODIAZEPINES IN PEOPLE WITH INTELLECTUAL DISABILITIES

Lead Author: Muhammad H. Burhanullah, M.D.

Co-Author(s): Mehnaz Waseem, M.D.; Muhammad W Khan, M.D.

ABSTRACT:
Introduction: Benzodiazepines have wide variety of the side effects including the paradoxical side effects such as aggression, agitation, hyperactivity, irritability, and property destruction . In patients with intellectual disability (mentally retarded) paradoxical side effects associated with BZDs can be easily overlooked and go unnoticed. These side effects can be inadvertently confused with other behavioral or psychiatric conditions. As the individuals with the mental retardation are dependent upon others for detecting and recognizing these side effects they cannot effectively communicate the presence of these side effects and this further complicates the problem.

Objective: This literature review aims to explore the published evidence on BZDs paradoxical side effects ,to better understand the proposed underlying mechanisms, treatment options and implications if not recognized.

Method: Literature Review

Discussion: People with intellectual disabilities are at increased risk of paradoxical reactions. This patient groups may not have developed the skills to control their behavior in adverse circumstances. BZDs-induced inhibition of neurotransmission may result in a decrease in the restricting effect of the cortex, leading to excitement, agitated toxic psychosis, increased anxiety, hostility and rage.

The individuals with mental retardation who were prescribed BZDs for either behavioral or psychiatric conditions overall rate of side effects is 13.0%. Out of all BZDs more frequently these side effects are reported with chlordiazepoxide, clobazam, clonazepam, diazepam, lorazepam, especially when prescribed for individuals with mental retardation.

Conclusion: The exact mechanism of paradoxical reactions remains unclear. However, it is important for both clinicians and patients to be aware of their potential to occur. A thorough medication history and careful inquiry regarding comparable adverse reactions should be completed.

The association between BZDs and paradoxical reactions has important implications for practice. We need to be able to predict who is at risk, as BZDs are widely used as the first line to control acute behavioral disturbance.True paradoxical reactions to BZDs probably are not completely unpredictable. Known risk factors include high-potency drugs, high doses being administered by parenteral routes to the very young, elderly, those with pre-existing CNS damage and those with a history of aggression or impulsivity.

It is important to be aware of the ability of BZDs to cause behavioural disinhibition and to maintain a high degree of vigilance when these drugs are administered to patients known to be at risk. Failure to recognize such a reaction could lead to the administration of higher doses of BZDs in an attempt to control the behavioural disturbance. In patients who have experienced a paradoxical reaction to BZDs, future behavioural emergencies should be managed with antipsychotic drugs.

P5-09
A CASE OF POST TRAUMATIC BRAIN INJURY PSYCHOSIS OR LATE ONSET SCHIZOPHRENIA?

Lead Author: Shanel Chandra, M.D.

Co-Author(s): Rashi Aggarwal, M.D.; Anbreen Khizar, M.D.

ABSTRACT:
Introduction: Psychosis due to traumatic brain injury (PDTBI) is a serious neuropsychiatric sequelae that can produce emotional and behavioral disturbance in the affected person. Incidence ranges from 0.7-20% and mean onset of

duration of symptoms from physiological insult ranges from 3 months to 19yrs. It is always a challenge to establish a relationship between TBI and psychosis. It is seen that majority of patients with PD-TBI also have history of seizures thus showing comorbidity between psychotic symptoms, head injury and seizure disorder. We report a patient who had TBI, seizure disorder and developed psychosis.

Case: We present a case of 55 year old African American female with no previous past psychiatric history, brought in by the family member as the patient was found to be hearing voices. Patient had suffered TBI followed by a bleed secondary to a seizure 1 yr ago. 6 months ago, patient started having paranoid ideation, feeling that neighbors upstairs are after her and trying to hurt her. Patient started feeling scared and was keeping to herself all the time. For the past 2 months, patient was found to be internally preoccupied with self-dialogue, hearing multiple voices, cursing her. Patient denied any symptoms of depression or mania.

Discussion: The most important differential in this case is schizophrenia, which usually is difficult to differentiate due to similar symptomatology. Patient's advanced age, temporal association with traumatic brain injury, predominance of psychotic features over negative symptoms and presence of concomitant seizures favored a diagnosis of PD-TBI over schizophrenia in this patient. PD-TBI could be added to the spectrum of presentation in post-concussion syndrome and further studies are warranted regarding prevention and management of PD-TBI.

P5-10
BETTER HEALTH OUTCOMES FOR PATIENTS WITH SCHIZOPHRENIA IN DEVELOPING COUNTRIES

Lead Author: Shana Neelu Coshal, M.D./MPH candidate 2014

ABSTRACT:
Objective: To demonstrate how cultural differences in developing countries (supportive family structure, community cohesion, and informal economies) produce better schizophrenic health outcomes when compared to modern medical treatment (institutionalization and pharmacology) employed in developed nations.

Schizophrenia is a critical illness requiring public health action due to its frequency, severity, disability, and treatable nature. The "International Pilot Study of Schizophrenia" conducted by the World Health Organization (WHO) in 1966 revealed little variation in incidence rates of schizophrenia across the world, but exposed that health outcomes of schizophrenia were overall superior in developing nations when compared to developed nations, despite having minimal medical treatment options. The follow-up study, "Ten Country Study", further determined that schizophrenic patients were healthier in developing countries due to increased stability during remission periods.

Remission longevity cannot be attributed to pharmacologic measures, as medication is only readily available to a small portion of patients in developing nations. Rather, the stability of these patients is accredited to the strong familial relationships often embedded in many cultures of Africa, Asia, and Latin America. In these regions, families are viewed as the primary caregivers for their ill relatives and are closely involved in their treatment, support, and rehabilitation. This is in contrast to developed nations where patients are more likely to be institutionalized and alienated from society. Developing countries also have informal or subsistence economies, which foster easier reintegration in the workforce. Predominantly agrarian societies have a greater job availability that does not require formal vocational training.

Community-based approaches incorporating the idea of advanced community care models have been successful in developing nations illustrating the importance of socioeconomic determinants of health. The WHO emphasizes the importance of culturally sensitive, family-based interventions that encourage early family participation in a patient's treatment plan while focusing on education and crisis intervention during times of stress or relapse. European countries have begun to concentrate on family intervention strategies and demonstrate that change on a small scale can be efficacious. The United States should begin to incorporate such practices in psychiatric care in order to enhance the quality of life of mental health patients by diminishing individual pain and suffering.

P5-11
MANIC EPISODE WITH PSYCHOSIS AS CLINICAL PRESENTATION OF PRIMARY SJOGREN'S SYNDROME: A CASE REPORT

Lead Author: Natasha Dalseth, M.D.

Co-Author(s): Kiran Majeed, M.D.; Mary F. Morrison, M.D., MS

ABSTRACT:
Introduction: Primary Sjogren's Syndrome (PSS) is a systemic autoimmune disease that is characterized by mononuclear cell infiltration and destruction of exocrine glands resulting in ocular and oral dryness. The majority of patients with PSS develop pulmonary, hematologic, renal, vascular and gastointestinal disorders, as well as nonfocal and focal neuro-psychiatric disease. We present a case of a 19 year old woman who developed a manic episode with psychotic features as part of CNS Sjogren's Syndrome. The patient was recently hospitalized for encephalitis accompanied by dysfunction in several major organ systems. Her condition improved dramatically after a course of IVIG.

Nine days after being discharged from the hospital, she presented with euphoria, irritability, social disinhibition, pressured hyperphonic speech, markedly decreased need for sleep, flight of ideas, auditory hallucinations and paranoid delusions. Extensive medical workup initiated during first hospitalization revealed positive SSA and SSB antibodies in peripheral blood. Treatment with Methylprednisolone, Quetiapine, and Haloperidol resulted in resolution of psychotic symptoms and reduced severity of mood disturbance.

Methods: We completed a review of literature on PubMed and Ovid using the following ***keywords:*** (1) Sjogren's Syndrome/Primary Sjogren's Syndrome/Sicca Syndrome/Autoimmune/Rheumatologic and (2)Manic/Mania/Bipolar/Psychosis/Psychotic/Psychiatric/Neuropsychiatric. This literature search was conducted to explore the link between autoimmune disease, Primary Sjogren's Syndrome in particular, and various neuropsychiatric clinical presentations.

Results: No report of a manic episode or bipolar disorder as an early manifestation of Primary Sjogren's Syndrome was found. Our literature search revealed case reports and studies that link PSS to depression, anxiety, personality disorders, somatization and cognitive dysfunction, whereas manic and psychotic symptoms have been described as part of clinical picture in other autoimmune disorders, such as Systemic Lupus Erythematosus, Multiple Sclerosis and Hashimito's Thyroiditis.

Conclusion: A manic episode can be an early manifestation of Primary Sjogren's Syndrome, and can occur in the absence of well recognised clinical features of mucosal dryness. PSS and other autoimmune disorders should be considered and investigated as a possible underlying cause of psychiatric syndromes. Early correct diagnosis of patients who present with acute onset psychosis or an episode of severe mood disturbance can lead to appropriate multidisciplinary management and better clinical outcome.

P5-12
BRINGING RECOVERY SUPPORTS TO SCALE TECHNICAL ASSISTANCE CENTER STRATEGY (BRSS TACS): PROMOTING RECOVERY SERVICES AND SUPPORTS

Lead Author: Livia Davis, M.S.W., CSWM

ABSTRACT:
The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) contract to the Center for Social Innovation (C4). The funding award, through C4 and its partners, establishes the BRSS TACS Team, a consortium dedicated to promoting wide-scale adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions.

This poster will present many of the peer-lead initiatives of the first year of the project in addition to the effort States have made to promote a more recovery-oriented system. Recovery and peer support services in the mental health and addiction systems are presented.

P5-13
ZOLPIDEM-INDUCED GALACTORRHEA VIA GABAERGIC INHIBITION OF DOPAMINE: A CASE REPORT

Lead Author: Daniella De Jesus, B.S.

Co-Author(s): Adekola Alao, M.D., MRCPsych, FAPM,

ABSTRACT:
Introduction: Insomnia, which can be defined as difficulty in falling and/or remaining asleep or simply reduced quality of sleep, can be secondary to a physical or psychiatric condition. The prevalence of insomnia has been estimated to be as high as 32 to 33% of the population. Non-benzodiazepines such as zolpidem have become more commonly used due to their more favorable adverse effect profile. In this report, we will describe a case of zolpidem-induced galactorrhea. We will also explore the mechanism leading to galactorrhea in this patient.

Case Report: The patient is a 29-year-old woman with a history of post traumatic stress disorder (PTSD) as well as alcohol abuse in sustained remission who presented with PTSD associated insomnia. She was started on zolpidem 5 mg po qhs. Two months after the initiation of zolpidem treatment, the patient presented with breast tenderness and galactorrhea. Zolpidem was discontinued and the galactorrhea resolved after two weeks. A serum prolactin level was drawn shortly after discontinuation of zolpidem and was measured to be 15.67 mg/ml.

Discussion: Zolpidem has a high affinity and is a full agonist at the ?1 containing GABAA receptors, with reduced affinity for those containing the ?2- and ?3- GABAA receptor subunits and minimal affinity for ?5 receptor subunit. Due to its selective binding, zolpidem has been found to have very weak anxiolytic, muscle relaxing and anticonvulsant properties while having very strong hypnotic properties.

Psychotropic drugs have been well recognized to produce hyperprolactinemia. However, there has been no reported case of zolpidem-induced hyperprolactinemia. Specifically, zolpidem has been noted to activate GABAergic neurons within the ventral tegmental area (VTA), where there is a sizable population of GABAergic neurons. These GABAergic neurons regulate the firing of dopaminergic coun-

terparts, also located in the VTA, which send projections throughout the brain. This inhibition results in a decrease in the dopaminergic inhibitory influence on prolactin and an increase in prolactin releasing factors which act on the anterior pituitary, leading to hyperprolactinemia and thus galactorrhea .

Conclusion: Pharmacologically induced hyperprolactinemia may be a problem of underestimated prevalence due to the lack of externally visible symptoms as well potential shame associated with reporting of symptoms. However, more research is needed in this area to definitively associate zolpidem with hyperprolactinemia and its related symptoms.

P5-14
AMYGDALA VOLUME AND HISTORY OF VIOLENCE IN SCHIZOPHRENIA

Lead Author: Victor DelBene, B.A.

Co-Author(s): Pierfilippo De Sanctis, PhD; Menachem I. Krakowski M.D.; John J. Foxe PhD; Lars A. Ross PhD

ABSTRACT:
Neuroanatomical morphology in schizophrenia has been widely reported in many regions, including the amygdala (Shepard et al., 2012). The amygdala has been implicated in perceptual fear response (LeDoux, 2000) and the processing of negatively valenced stimuli in patients with schizophrenia (De Sanctis et al., 2012). We performed a structural analysis on T1- weighed images acquired on a 1.5 T MRI scanner and compared amygdala volumes of violent (N = 37) and non-violent (N = 31) patients with schizophrenia, with matched controls (N = 29). Mean bilateral amygdala volumes were significantly smaller in non-violent schizophrenics (M = 1128.676, SD = 224.11) than in healthy controls (M = 1257.208, SD = 162.67; t(58) = 2.53, p = .014). No other significant group differences were found. This is in line with previous reports on amygdala volume in violent and non-violent schizophrenics (Barkataki et al., 2006). A reduced amygdala volume may lead to reduced fear perceptions. Reduced amygdala volume is also associated with negative symptoms , which is in turn is not related to aggressive tendencies (Arango et al., 1999). There is evidence that violent schizophrenics with structurally intact amygdalae may show inhibitory deficits resulting from structural reductions in the orbitofrontal cortex, particularly the left hemispheric grey matter and bilateral white matter (Hoptman et al., 2005). To further investigate possible links between amygdala structure and indices of early sensory perceptual processes we will assess volumetric and electrophysiological measures that were acquired from the same participants.

P5-15
"ATTACK OF THE ALIENS": A CASE OF RAPID RESOLUTION OF MYXEDEMA MADNESS

Lead Author: Sonia Demetrios, M.D.

Co-Author(s): Alan Arauz M.D.- Aasia Sye,M.D., Dr. Lavakumar

ABSTRACT:
Background: Psychosis associated with hypothyroidism was first identified in 1888. Since then there have been numerous reports of identification and successful treatment of this syndrome. A review of the literature indicates that the typical time frame for resolution of psychosis is weeks to months. Given the functional and safety implications of psychosis and the mental distress associated with it more expeditious treatments are desired. We report a case where severe psychosis secondary to hypothyroidism was treated to complete resolution within 2 days.

Case Report: Mr. X is a 49 year old man with no prior psychotic history who was brought in by police to the emergency department of a Midwestern academic county hospital. According to the police report his apartment was found to have blood stains and was destroyed. He stated that he was being attacked by aliens. On exam tendons of the right ring and little fingers were completely severed and he was bleeding profusely. Also of note he had a hoarse voice and pretibial myxedema. He described that he saw microscopic aliens emerge from his clothes and collect together as one giant alien. The alien then threatened to kill him and his girlfriend. In order to protect himself, he had attempted to kill the alien with a metal bar and consequently injured his hand. He was taken for emergent surgery. His vitals were stable and his neurological exam was unremarkable. TSH, T4, and anti-microsomal antibodies were 83.2, 0.4 mμU/ml, 8.74 IU/ml respectively. BMP, CBC, LFTs, ammonia level, B12, folic acid, VDRL, HIV, urinalysis, urine toxicology and serum alcohol were either within normal limits or negative. No abnormalities were detected on CXR or head CT. He was started on Thyroxine 200 mg IV, followed by 200 mg oral Levothyroxine. Olanzapine 10mg was initiated as an adjunct treatment to thyroid replacement. After 2 days of receiving treatment, the paranoia and visual hallucinations resolved.

Discussion: Most cases of myxedema madness have been treated with thyroid replacement. It is highly unusual for symptoms to resolve rapidly. There have been only two case reports of rapid resolution and in neither of these cases antipsychotics were used as adjunct treatment. This is the first report of rapid resolution of psychosis with olanzapine as an adjunct treatment to thyroid supplementation for hypothyroidism associated psychosis.

Conclusion: Recognition of this syndrome is critical for institution of appropriate therapy and in prevention of psychosis. Sometimes patients may be mislabeled with schizophrenia if proper laboratory analysis is not instituted, as it may have occurred with this patient. Treatment with an antipsychotic as an adjunct to thyroid replacement could lead to more rapid resolution of psychosis secondary to hypothyroidism.

P5-16
WHEN PSYCHIATRIC SYMPTOMS ARE NOT CAUSED BY PSYCHIATRIC ILLNESS: A CASE OF CREUTZFELD-JACOB DISEASE (CJD) MASQUERADING AS MDD WITH PSYCHOTIC FEATURES

Lead Author: LaShire Diegue, M.D.

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ABSTRACT:
Introduction: Most inpatient psychiatric units have protocols that include medical clearance prior to admission to psychiatry. However, missed medical causes of psychiatric symptoms still persist. One study reviewed 64 such cases that were erroneously admitted to psychiatric units. Another study showed that 9.1% of their psychiatric outpatients had psychiatric symptoms that were produced by medical disorders. The most common psychiatric symptoms were depression, confusion and anxiety as well as speech or memory disorders.

Case: We report of a 42 year old Ecuadorian woman who had been diagnosed with Major Depressive Disorder (MDD) 3 weeks prior to presentation and was started on Sertraline 25mg po daily by a primary care physician. Patient presented with symptoms consistent with MDD with psychotic features. Initial laboratory tests, including a complete blood count were within normal limits. Patient was admitted to the inpatient psychiatric unit and treated with Sertraline and Haloperidol. A CT Head was ordered to rule out organic etiology of symptoms and showed a possible hemangioma. A follow up MRI was unremarkable. On day 16 of patient's hospitalization, patient became mute, stopped eating and would stand in one place for hours. Patient was treated for catatonia with Lorazepam. Due to observed confusion and fall, CT Head and MRI were repeated. CT Head was unremarkable but MRI showed increased diffusion and FLAIR signaling in both caudate heads, putamen and left frontal lobe from previous MRI. EEG was ordered and patient was found to be in status epilepticus. Patient was transferred to the intensive care unit and place in a pentobarbital coma to stop seizure activity. Initial lumbar punture (LP) was negative for syphyllis, strep pneumoniae, and cryptococcus. Repeat LP results found ANA was 1:320 titer but HSV, JC, anti-dsDNA, AFB, and ANCA were all negative. Neurosurgery was consulted for a possible brain biopsy but declined. 14-3-3 protein was later found to be positive as well as the ELISA tau protein assay which was found to be 16543 pg/ml where the cutoff is 1200 pg/ml. This finding is consistent with probable CJD. Patient died 49 days after admission.

Discussion: The initial presentation of CJD can be quite variable but often includes a psychiatric presentation and about 80% of patients will develop psychiatric symptoms during the course of the illness. In fact 10% of CJD cases are admitted to psychiatric units. Although there are characteristic EEG findings in CJD (periodic triphasic sharp waves), up to 60% of patients will not present with these EEG findings. Although there is no cure for CJD, the attention given to the possibility of an organic etiology for patient's atypical presentation, led to the correct diagnosis. Had the illness been treatable, the diagnosis could have meant the difference between life and death.

P5-17
HEALTHCARE USE AND COST OF PATIENTS WITH SCHIZOPHRENIA TREATED WITH PALIPERIDONE PALMITATE OR ATYPICAL ORAL ANTIPSYCHOTICS IN A VA POPULATION

Lead Author: Mike Durkin

Co-Author(s): L Xie, J Pesa, M Durkin, Z Clancy, O Baser

ABSTRACT:
Objective: To compare health care utilization and costs of a matched cohort of schizophrenia patients treated with paliperidone palmitate long-acting injection (PP) or atypical oral antipsychotic therapy (OAT) within the Veterans Health Administration (VHA).

Methods: Patients age 18-64 years were selected from a national database of medical and pharmacy claims from the Veterans Health Administration (VHA) for the period July 2007 to May 2012. Patients with two claims for PP within 60 days of each other were included in the PP cohort. Patients with no claims for PP and two claims for the same atypical OAT within 60 days of each other were included in the OAT cohort. For each patient the date of the first claim for their cohort drug was designated as index date. Patients were required to have continuous medical and pharmacy benefits 24 months pre- (baseline period) and 12 months post-index date (follow-up period), a schizophrenia diagnosis (International Classification of Disease 9th Revision Clinical Modification [ICD-9-CM] code: 295.x) and at least one claim for an antipsychotic in the baseline period. Baseline characteristics were compared between the two unmatched cohorts using t tests for continuous variables and Chi-square tests for categorical variables. Through logistic regression analysis, propensity scores (pscores), representing the likelihood of receiving PP, were calculated for all study patients. A stringent 1:1 propensity score matching process was used to

create two matched cohorts within the range defined by the lowest PP pscore and the highest OAT pscore. Utilization and cost outcomes were compared between the matched cohorts, also using chi square and t tests.

Results: A total of 5,377 patients were eligible for the matching process. The propensity matching process resulted in two well-matched cohorts of 277 patients each. Pscore distribution and baseline characteristics appeared similar for the matched cohorts. There were no significant differences in demographics such as mean age (50.34 vs. 50.36 years, p=0.9970) or gender (90.61% vs. 91.70% male, p=0.6535) or in resource use and costs over the 24 month pre-index baseline period, including the % with ?2 antipsychotics in the baseline period (72.56% vs. 70.40%, p=0.5724), baseline hospitalization rates (61.01% vs. 62.45%, p<0.7266) or 24 month mean total costs ($74,547 vs. $74,393, p<0.9814). For the 12 month follow-up period, patients in the PP cohort had a lower hospitalization rate (32.49% vs. 55.60%, p<0.0001) and nominally lower mean total health care costs ($40,535 vs. $51,465, p=0.1473) relative to the OAT cohort.

Conclusion: Among a matched cohort of VHA patients diagnosed with schizophrenia and treated with PP or OAT, PP was associated with lower hospitalization and nominally lower total cost than OAT over a 12 month period.

P5-17
FACTORS ASSOCIATED WITH PERFORMANCE ON HEDIS MEDICAID QUALITY MEASURES FOR PATIENTS WITH SCHIZOPHRENIA

Lead Author: Mike Durkin

Co-Author(s): Marie-Hélène Lafeuille; Christian Frois; Michel Cloutier; Jonathan Gravel; Mei Sheng Duh; Patrick Lefebvre; Jacqueline Pesa; Zoe Clancy; John Fastenau; Mike Durkin

ABSTRACT:
Introduction: The National Committee for Quality Assurance uses four Healthcare Effectiveness Data and Information Set (HEDIS) measures to evaluate the quality of care provided by Medicaid plans to their patients with schizophrenia.One is a medication-related measure, adherence to antipsychotic (AP) medications (M1), and three are comorbidity-related measures:diabetes screening (M2), diabetes monitoring (M3), and cardiovascular monitoring (M4).

Objective: To identify the claim-based factors predictive of success on the four Medicaid schizophrenia HEDIS quality measures and explore the effect of AP use.

Methods: Four quality measures were evaluated for 2011 (measurement year) based on the HEDIS technical specifications using Medicaid claims data from five states.Among eligible patients, success was defined for M1 (adherence to AP) as proportion of days covered with AP medication ?80%, for M2 (diabetes screening) as ?1 glucose or HbA1C test, for M3 (diabetes monitoring) as ?1 HbA1C and ?1 LDL-C tests, and for M4 (cardiovascular monitoring) as ?1 LDL-C test. The effects of patient demographics, clinical characteristics (e.g., Charlson Comorbidity Index [CCI]), resource utilization and medical costs from 2010 (baseline year) on HEDIS success were analyzed using adjusted odds ratios (OR) and 95% confidence intervals (CI) from multivariate logistic regression models for each measure.Baseline AP use was characterized by four (non-exclusive) factors: ?1 claim for any AP, ?1 claim for any long-acting AP, ?1 claim for paliperidone palmitate (PP), no AP claims. Baseline pharmacy costs were used as a potential predictive factor for comorbidity-related measures.

Results: Observed success rates on the HEDIS measures (M1:46.3% in 14,250 patients [pts]; M2:75.4% in 17,851 pts; M3:50.5% in 4,567 pts; M4:52.6% in 1,449 pts) were consistent with previous National Quality Forum analyses.While CCI was found to be a significant predictor of measure performance (p<0.05) for each quality measure, other demographic and resource utilization characteristics varied in significance among the measures.For the adherence measure (M1), after controlling for other baseline factors, presence of baseline year AP claims was associated with a two-fold increase in the likelihood of goal achievement as compared to no AP baseline claims (OR:2.37; 95% CI:2.02-2.78) and baseline PP use was associated with a 26% greater likelihood of adherence as compared to no-PP use (OR:1.26; 95% CI:1.02-1.55).For comorbidity-related measures (M2-4), AP utilization factors were not significantly associated with HEDIS performance, with the exception of M2, for which ?1 baseline AP claim was associated with a 32% lower likelihood of success (OR:0.68; 95% CI:0.60-0.77).

Conclusion: This study identified a number of factors predictive of success on the four Medicaid HEDIS measures for patients with schizophrenia. These results may help inform efforts to improve the quality of care for this unique population.

P5-19
OUTPATIENT FOLLOW-UP AFTER HOSPITALIZATION AND RISK OF REHOSPITALIZATION FOR PATIENTS WITH SCHIZOPHRENIA IN A MEDICAID POPULATION

Lead Author: Mike Durkin

Co-Author(s): Zoe Clancy, Steven C Marcus

ABSTRACT:
Background: The NCQA Follow-up After Hospitalization for Schizophrenia HEDIS quality indicator for Medicaid plans reflects the importance of transition from inpatient to outpatient care for patients with schizophrenia. Success on the quality indicator is defined by a claim for a qualifying mental health outpatient visit within 30 days of discharge from hospital. We examined the association of the quality indicator with risk of hospital readmission.

Methods: A retrospective cohort analysis was performed using a multi-state Medicaid database on claims for patients 18-64 years old discharged from a hospitalization for schizophrenia in calendar years 2007-2011 and continuously enrolled for 6 months prior to and 5 months after this index discharge. The percentage of patients meeting the 30 day follow-up indicator was determined overall and stratified by patient demographic and clinical characteristics. The rate of hospital readmission during the following 60-days (31 to 91 days post hospital discharge) was compared between patients who succeeded or failed to meet the 30 day standard using chi-square tests. Logistic regressions were fit for each strata with quality indicator status (success or failure) as the independent variable, psychiatric hospital readmission during the 60-day follow-up period as the dependent variable and sociodemographic characteristics as covariates. Adjusted odds ratios (AOR) and 95% confidence intervals (CI) were calculated from the regressions.

Results: From a cohort of 9,535 eligible discharged patients, 64.7% (n=6172) were successful on the 30 day follow-up quality indicator. Successful patients were significantly less likely to have a psychiatric hospital readmission in the following 60 days as compared with patients who failed to meet the quality indicator, (16.8% vs. 18.9%, p=0.02, AOR=0.88, 95%CI: 0.78-0.99). In patients who had not received outpatient mental health care in the 30 days prior to the index hospitalization, patients successful on the quality indicator were less likely to have a psychiatric hospital readmission than those failing on the indicator (15.1% vs. 18.7%, p<0.01, AOR=0.78, 95%CI: 0.65-0.94). Similarly, among patients with a psychiatric hospitalization during the 6 months preceding the index hospitalization, success on 30 day follow-up was associated with a lower rate of readmission than failure to meet the standard (24.6% vs. 28.7%, p=0.01, AOR=0.83, 95%CI: 0.71-0.98).

Conclusions: Within an adult Medicaid population with schizophrenia, success on the 30 day follow-up care indicator was associated with a lower likelihood of hospital readmission during the subsequent 60 days. This relationship held in the subgroup of patients not in active outpatient care at the time of the initial hospital admission and in those with ?1 prior hospitalization in the preceding six months. These findings support the importance of care transitions from inpatient to outpatient for patients with schizophrenia.

P5-20
NEGATIVE SYMPTOMS AND FUNCTIONAL OUTCOME IMPROVE AFTER GROUP COGNITIVE REMEDIATION TREATMENT (REHACOP PROGRAM): A RANDOMIZED CONTROLLED TRIAL

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Co-Author(s): Jesus Ezcurra M.D., Natalia Ojeda Ph.D., Javier Peña Ph.D., Gemma Garcia M.D., Olatz Napal M.D., Miguel Gutierrez M.D.

ABSTRACT:
The efficacy of cognitive remediation in patients with schizophrenia has been recognized for cognitive impairment. However, clinical symptoms (particularly negative symptoms) and functional outcome do not show the same pattern/level of improvement. Therefore, the goal of this study was to test if clinical symptoms and functional disability improve after group cognitive remediation with a neuropsychological tool which includes cognitive rehabilitation and activities of activation: the REHACOP program.

Purpose: To analyze the objective changes in cognition but also in clinical symptoms, in patients with schizophrenia after cognitive remediation.

Method: Eighty-four patients with chronic schizophrenia were randomly allocated into experimental or control groups. The patients allocated on the experimental group (N= 36) received a group cognitive rehabilitation treatment using REHACOP. They attended 36 sessions of 90 minutes during three months. During the same time and frequency, patients under control condition (N=48) were involved in occupational activities. Both groups received treatment as usual (TAU). Patients underwent clinical, neuropsychological, and functional outcome pre- and post treatment assessments.

Results: Repeated measures of MANOVA showed that Group (REHACOP vs occupational therapy) x Time (pre vs post-treatment) interactions were significant for negative symptoms (F=4.89, p<0.05), disorganization (F=7.32, p<0.01) and emotional distress (F=4.42, p<0.05) showing that experimental group obtained significant improvement when compared to controls. Regarding functional outcome measures, Group x Time interaction was significant for DAS-WHO (F =6.26, p<0.01) and GAF (F =5.64, p<0.05). On the contrary, excitement (F = 1.64, n.s.), CGI (F = 2.74, n.s.) and positive symptoms (F = 2.10, n.s.) did not significantly improve.

Importance/Relevance: Our results suggest that REHACOP is an effective group cognitive remediation program for minimizing existing cognitive and clinical symptoms, and functional disability. These findings support the feasibility of integrating neuropsychological rehabilitation into TAU

programs for patients with lower responses to other treatment plans.

P5-21
VETERANS AND NON-VETERANS WITH SEVERE MENTAL ILLNESS: A GROUNDED THEORY COMPARISON OF PERCEPTIONS OF SELF, ILLNESS, AND TREATMENT

Lead Author: Ruth L. Firmin, B.A.

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ABSTRACT:
Background: Individuals with severe mental illness (SMI) often experience poor insight, which contributes to poor treatment adherence, higher relapse risk, and poorer outcomes. Veterans with mental illness are particularly reluctant to engage in treatment. Veterans also experience increased rates of trauma and comorbid diagnoses that can be compounding barriers. Given the stigma and the added barriers veterans face regarding treatment utilization, there is a need to better understand the ways veterans with mental illness perceive their condition and recovery.

Study aims: This study investigates differences between veterans and non-veterans with SMI regarding perceptions of their illness, themselves, and treatment. Findings have implications for treatment needs particular to veteran populations.

Methods: We compared patient interviews (using the Indiana Psychiatric Illness Interview, IPII) of veterans (N=20) and non-veterans (N=26). Interviews were audio-recorded, transcribed, de-identified, and coded using modified grounded theory. Codebooks were developed for each group and compared for differences. We examined differences in code frequency and meaning.

Results: More veterans than non-veterans were male, employed, married, and had higher income (all $p < .05$). Key differences in narratives related to (1) views of the future, with veterans consistently being more optimistic and relationship-oriented. (2) Veterans were more active, rather than passive, when talking about their attitudes toward treatment and conceptualization of their illness. For many veterans this included a "military mindset" of bravery, fighting, or resisting symptoms. (3) Veterans' views of their recovery were more likely to include more than just medication maintenance. (4) More veterans brought up and included anger and aggression in their discussion of their mental health.

Discussion: Compared to non-veterans, veterans appear to have several protective factors (i.e., finances, social support, and education). These are strengths to highlight and build upon in treatment, for example, when promoting agency and encouraging patient activation. Veterans' "military mindset" seemed to impact the way treatment, symptoms, and recovery were viewed. Understanding this perspective may give clinicians better insight regarding potential barriers or treatment preferences. Finally, veterans emphasized issues relating to anger as important and part of their mental health. It may be that veterans are more comfortable discussing mental health in the language of "anger," given stigma.

P5-22
PATIENT FUNCTIONING AND MEDICATION SATISFACTION WITH PALIPERIDONE PALMITATE FOLLOWING TREATMENT OF ACUTE EXACERBATION OF SCHIZOAFFECTIVE DISORDER

Lead Author: Dong-Jing Fu, M.D., Ph.D.

Co-Author(s): I Turkoz, RB Simonson, D Walling, N Schooler, J-P Lindenmayer, J Panish, L Alphs,

ABSTRACT:
Introduction: Patient functioning and treatment satisfaction are important aspects of therapeutic response in serious mental illnesses like schizoaffective disorder (SCA). This analysis examined functioning using the Personal and Social Performance (PSP) scale and medication satisfaction using the Medication Satisfaction Questionnaire (MSQ) at the end of the 25-week open-label (OL) phase of a maintenance study in SCA (a randomized, double-blind [DB], placebo-controlled international study of the long-acting injectable antipsychotic paliperidone palmitate [PP]).

Method: This analysis of OL data is from an ongoing, multiphase study in patients with acute exacerbation of SCID-confirmed SCA (NCT01193153). Subjects stabilized on PP (78–234 mg/mo) during a 13-week OL flexible-dose period continued into a 12-week OL fixed-dose period. Those maintaining stability in this OL phase were randomized to PP or placebo in a 15-month DB phase. Assessments included CGI-S-SCA, PSP, and patient-rated MSQ. The CGI-S-SCA is scored 1–7 (normal to most severely ill). The PSP is scored 1–100 (higher score indicates better functioning) based on evaluation of four domains (socially useful activities, personal and social relations, self-care, and disturbing/aggressive behaviors); the level of function for each PSP domain is assessed on a 6-point severity scale: absent, mild, manifest, marked, severe, and very severe. The MSQ is a 7-point scale: 1 = extremely dissatisfied to 7 = extremely satisfied. Data from the OL phase are presented using all subjects who had at least one injection. Mean changes from baseline to OL LOCF end point were examined using a paired t-test. No adjustment was made for multiplicity.

Results: 667 subjects enrolled; 349 subjects completed the OL phase. Mean (SD) age: 39.5 (10.7) years; 54% male; 49% on PP monotherapy, 51% on adjunctive antidepressants (AD) or mood stabilizers (MS). Mean (SD) baseline CGI-S-SCA and PSP total scores: 4.4 (0.6) and 51.6 (10.9), respectively. Mean (SD) change at end point in CGI-S-SCA score: -1.3 (1.1) ($P<0.001$). Mean (SD) PSP score improvement at end point: 13.6 (14.9) ($P<0.001$). Subjects with manifest to very severe impairment on the PSP domains of socially useful activities and personal and social relations decreased from 92.2% and 89.1% at baseline to 58.6% and 46.0% at end point. Subjects with manifest to very severe impairment on the PSP domains of self-care and disturbing/aggressive behaviors decreased from 28.9% and 36.7% at baseline to 11.9% and 9.9% at end point. The proportion of subjects "satisfied" with their medication per MSQ score (5–7) increased from 38.2% at baseline to 75.1% at end point.

Conclusion: OL results suggest that functioning and medication satisfaction improved in tandem with symptom improvement during 25 weeks following treatment with PP as monotherapy or adjunctive to MS/AD in acutely ill subjects with SCA.

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P5-23
UNUSUAL PRESENTATIONS OF CATATONIA: A CASE REPORT

Lead Author: Anupriya Gogne, M.B.B.S., M.D.

Co-Author(s): Dr. Amjad Hindi

ABSTRACT:
Catatonia is a syndrome of motor dysregulation with a varied range of clinical presentations. Cases of retarded catatonia have been reported in history as Kahlbuam syndrome, where severe psychomotor retardation in patients is seen as a form of immobility which can be induced by severe psychological trauma in some cases. In some patients, the signs persist over long periods; in others, recurring over shorter intervals. Periodic catatonia with alternating episodes of stupor and excitement is also known. The root cause behind severe psychomotor retardation, as well as the periodic nature of manifestations remains inexplicable. Our attempt here, through discussion of case histories of two men with unusual periodic presentations of catatonia, is to explore plausible etiological explanations. We consider the case of a middle aged man having multiple episodes of selective mutism, severe psychomotor retardation to complete immobility, negativism, poor self care and self isolation; in his case, the onset of symptoms having a relation to extreme psychological trauma. His symptoms could not be fully explained by known etiologies of catatonia, however, it is possible, among other explanations, that these periodic catatonic states were a part of PTSD, manifesting as affective blunting, extreme isolative behaviours, and motoric immobility as a result of profound psychological shock. Such unusual presentations of PTSD have been documented in the literature. The patient also displayed severe psychotic symptoms which surfaced once catatonia started resolving. Hence, this was a case of periodic catatonia in the context of PTSD and psychosis. On the other hand, we encountered another young man showing similar patterns of stupor but, alternating with episodes of excitation. In this case, there were some unexplained findings of seizure activity on EEG and heightened sensitivity to extra pyramidal side effects in response to antipsychotics. We propose that such cases pose a diagnostic dilemma as they cannot be placed into any one etiologic category of catatonia, as perhaps there are multiple causes that need to be studied more extensively. Comprehensive work up in conjunction with neurological and radiological investigations to rule out organic causes is warranted. Further research is required in this field for better outcomes and recovery of patients with such atypical yet fascinating symptomology.

P5-24
THE RECOVERY MODEL: "PATH TO RESTORATION OF FUNCTION"

Lead Author: Nihit Gupta, M.B.B.S., M.D.

ABSTRACT:
Discussion of a rare presentation of delusion disorder of the somatic type when multiple confounding factors complicated deducing the correct diagnosis and exploration and elimination of differential diagnosis resulted in multiple trials of psychotropic medications including Clozapine and depot anti psychotics which was minimally helpful. It was possible to ameliorate severest symptoms which ultimately allowed the successful application of the recovery model. In the absence of cure, it is still possible to substantially improve the quality of life of a patient with chronic mental illness.

P5-25
CASE REPORT: PSYCHOTIC DISORDER DUE TO TRAUMATIC BRAIN INJURY

Lead Author: Nihit Gupta, M.B.B.S., M.D.

ABSTRACT:
Psychosis is a rare but devastating outcome in patient who sustain head injury. Presenting a case of a 66 year old Caucasian female with no past psychiatry history who developed sudden cognitive decline and psychosis with strong temporal association with bilateral subdural hematoma 2 years ago. This poster is an attempts to analyse data and gather latest evidence in order to describe common characteristics of psychosis secondary to brain injury, differential diagnosis and differentiation from late-onset schizophrenia,

the risk factors and evidence based treatment options for this form of psychosis.

P5-26
ROLE OF PARIETAL LOBE IN SCHIZOPHRENIA: LONGITUDINAL STUDY OF GRAY MATTER VOLUME

Lead Author: Taiga Hosokawa, M.D., Ph.D.

Co-Author(s): Martha E. Shenton, Ph.D., Margaret Niznikiewicz, Ph.D., Robert W. McCarley, M.D.

ABSTRACT:
Introduction: Some schizophrenia studies suggest progressive gray matter (GM) volume reduction in the frontal and temporal lobe in the patients. However, few studies have evaluated the parietal lobe despite the fact that it has an important role in attention, memory and thought which have been reported to be abnormal in schizophrenia.

Methods: To clarify how the parietal lobe is involved in the pathology of schizophrenia, we performed cross-sectional and longitudinal studies in first-episode schizophrenia (FESZ) and first-episode affective psychosis (FEAFF, mainly manic) patients. We examined GM volume changes of the parietal lobe by magnetic resonance imaging (MRI) scans. MRI scans with a 1.5-Tesla magnet were obtained from 21 FESZ and 24 FEAFF at first hospitalization for psychosis and 23 healthy control (HC) subjects matched for age, gender, parental socioeconomic status and handedness. They underwent follow-up scans approximately 1.5 years later on the same scanner. We segmented the parietal lobe into five subregions which are angular gyrus (AG), supramarginal gyrus (SMG), postcentral gyrus (PCG), superior parietal gyrus (SPG) and precuneus. Then we performed gyri-based manual drawing to calculate the volumes. We also analyzed the correlations between the changes of GM volumes and clinical symptom measures.

Results: Group comparisons revealed that the bilateral AG, PCG and precuneus GM volumes in FESZ patients were significantly smaller than those of HC subjects at the initial scans as well as the follow-up scans, while FEAFF patients didn't show any significant differences compared to HC. Longitudinally, the decreases of the bilateral AG were significantly larger than those of other subregions. Some changes of clinical scores of BPRS and PANSS including thought disturbance correlated with the GM volume changes.

Conclusions: Patients with new-onset schizophrenia showed smaller bilateral AG, PCG and precuneus GM volumes than healthy subjects even at the early stage of the illness. Longitudinally, the bilateral AG volumes decreased progressively after onset. FESZ patients showed progressive GM reduction in the inferior parietal lobe particularly localized to AG. The inferior parietal lobe is the brain region that plays a critical role as a biological substrate of thought. The inferior parietal lobe and precuneus belong to the default mode network which corresponds to self-referential thought. This suggests that the inferior parietal lobe may be a neuroanatomical substrate of thought disorder in schizophrenia. This finding contributes to more comprehensive understanding of the expression of schizophrenia.

P5-27
REVISITING THE ROLE OF ASCORBATE IN THE TREATMENT OF PSYCHOSIS: A CASE REPORT AND REVIEW OF THE LITERATURE

Lead Author: Daniel Kanofsky, M.D., M.P.H.

Co-Author(s): J. Daniel Kanofsky, M.D., MPH; Dmitri Bronovitski, M.D.; Mary E. Woesner, M.D.

ABSTRACT:
In the late 1980's, several studies suggested ascorbic acid may augment the therapeutic response to neuroleptics in psychotic patients (1,2). Since then, there has been little follow-up. In 1988, Kanofsky et al (3) proposed a mechanism to explain the suspected antipsychotic enhancing effect of ascorbic acid. It highlights ascorbate's role as the physiological reductant in the dopamine beta-hydroxylase reaction that converts dopamine to norepinephrine. This reaction is probably the rate limiting step in the tyrosine-to-norepinephrine pathway. If so, an excessive and clinically deleterious accumulation of dopamine could result from ascorbic acid insufficiency.

We discuss the case of a 60 year old, white female diagnosed with schizoaffective disorder and mild hypothyroidism. Over the course of her thirty year illness, she responded well to small amounts of neuroleptics such as fluphenazine and perphenazine. When she became medication non-compliant - which was often - she required hospitalization within days of neuroleptic discontinuation. Her symptoms included wandering behavior, mutism, thought blocking, irritability, paranoid ideations, and self-neglect. Her reasons for stopping antipsychotics were "stigma" and "I can't stand still," and her medication non-compliance led to her placement on the Assertive Community Treatment (ACT) team. After more than a year of treatment and several hospitalizations due to neuroleptic discontinuation, the team recommended she increase her ascorbic acid intake to 3 grams po bid. The goal was to lower her concurrent dose of perphenazine and reduce her akathisia. Upon follow-up, it became apparent that the patient exceeded the treatment recommendation by taking ascorbic acid 7.5 grams po bid, while stopping her 6 mg perphenazine dose. Due to abdominal distress, the dose of ascorbic acid was lowered back to 5 - 6 grams po bid.

The patient functioned well in the community for 15 months, with no akathisia. During this time, her only psychiatric medication was ascorbic acid and she underwent only one psychiatric hospitalization. It was brief and occurred when she was ill with nausea and jaw pain "unable to swallow medication" for several days, when she was without ascorbic acid and thyroid medication.

We review and update the literature on vitamin C and psychotic illness and further elaborate and comment on our case, in which a very low dose of an antipsychotic medication was replaced by a large dose of ascorbate without seeming to compromise clinical efficacy.

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P5-28
THE USE OF A NOVEL URINE DRUG MONITORING TEST TO HELP ASSESS HOW WELL CLINICIANS PREDICT ANTIPSYCHOTIC MEDICATION NON-ADHERENCE

Lead Author: Matthew Mason Keats, M.D.

Co-Author(s): Harry Leider M.D., MBA, Kathryn Bronstein, PhD, RN, Mary Anne Lang, MS, RN-BC

ABSTRACT:
Introduction: Prior research has established the critical role of maintenance antipsychotic pharmacotherapy in the management of schizophrenia, schizoaffective disorder, and bipolar disorder. Yet adherence to these drugs is a significant challenge for treating clinicians, and studies show that 50% of patients with these disorders do not take their antipsychotics consistently.

Despite the key role of the prescribing psychiatrist in identifying and addressing non-adherence, relatively few studies have addressed how well psychiatrists and other prescribers are able to detect non-adherence. Furthermore, most of these studies relied on indirect measures such as pill counts, pharmacy refills, and electronic monitoring.

Methods: The current study utilizes a novel drug monitoring test to detect the presence of antipsychotic drugs and metabolites in urine and reports on the results of a pilot study comparing behavioral health clinicians' assessment of whether or not their patients were taking the antipsychotic(s) they prescribed as directed with the results of the urine monitoring test.

Three psychiatrists and two psychiatric nurse practitioners working in a community mental health setting recorded their assessments for patients prescribed long-term antipsychotic medication. Subsequently, urine drug samples were obtained from these patients and analyzed for the presence of any of seven different antipsychotics using liquid chromatography/tandem mass spectrometry. The urine test result was then compared to the prescriber's assessment for the presence or absence of prescribed antipsychotic(s).

Results: Of the 47 patient samples, 37 were classified as coming from patients the clinicians predicted would have the antipsychotic medication present in their urine and 7 were classified as coming from patients where the clinician suspected non-adherence. Three samples had no clinician impression of status recorded.

Of the 37 samples from patients believed to be taking their antipsychotic medication, drug was detected in only 28 samples. Thus, clinicians misclassified 9 out of 37 samples. Additionally, 15% (7/47) of samples also had a non-prescribed medication detected in the urine, while 17% (8/47) of the samples contained illicit drugs and/or alcohol.

Overall, 43% of the samples evidenced some abnormality.

Conclusion: Utilizing a novel laboratory technology that directly detects the presence of antipsychotic in urine, this study produced findings consistent with existing literature regarding the relatively poor accuracy of clinical assessment of antipsychotic non-adherence. Given the serious consequences of antipsychotic non-adherence, the use of an easily administered, highly sensitive laboratory test may afford clinicians a new tool to more accurately identify antipsychotic non-adherence.

Ameritox funded this research and will pay for the author's travel expenses and poster production.

P5-29
PRELIMINARY REPORT OF A HOSPITAL BEHAVIORAL CRISIS RESPONSE TEAM LEAD BY PSYCHIATRY

Lead Author: Cheryl Ann Kennedy M.D.

Co-Author(s): Peter Sangra, M.D.; Ritesh Amin, M.D.; Nancy Rodrigues, BA

ABSTRACT:
Background: Behavioral crises are sensitive and difficult incidents in hospitals. Lack of training may lead responders

like security personnel to intervene using physical restraint, when, a verbal, environmental or pharmacological intervention may have been successful. Also, doctors or nurses may lack adequate training in safe physical restraint, leading to dangerous outcomes for patients and health care staff. In response to a recent NJ law, our tertiary care, academic, inner-city medical center developed a multi-disciplinary Crisis Response Team (CRT) for medical-surgical units and Psychiatric units. The behavioral CRT is a 24/7 'on-call' team composed of the patient's primary nurse (most commonly activates the CRT), a Psychiatrist, a Psychiatric nurse specialist, Psychiatric aide, and a Uniformed Public Safety Officer. The team piloted in June 2010 and was finalized in December 2010. We evaluated how the teams followed policy and procedure over a 26 month period to determine completeness of documentation (following policy and procedure), what variables may influence calls or outcomes of calls (demographics, admitting diagnosis, intervention used, co-morbid psychiatric diagnosis, etc.)

Method: We did a retrospective review of operator call logs & patient records of CRT calls from June 2010 to August 2012. Some variables studied were number of calls per day, type of disturbances, gender, age, location, number of responders, diagnosis, medication used, use of restraints along and proper documentation of the incident.

Results: During the study period, calls to CRT were 42 (2010; 6 months), 49 (2011), & 97 (2012; 8 months) for a total of 188 calls. There was a 10% increase in calls during night shifts (7:00 PM to 5:00 AM) accounting for 54.9% (n=184), compared to the day shift (45.1%). Aggression or combativeness calls were most frequent (26.4%; n=140); next was agitation (22.9%), and verbal aggression (15%). Majority of calls were for males 75.3% (n=97) and the most common age group was 31 to 50 (46.8%; n=94). Restraints were used 62% of the time (n=90); top three locations for CRT calls were Psychiatry Inpatient Unit (16%), Emergency Department (15.5%), and Neurology Stroke Unit (11.3%).

Discussion: Psychiatrists have a prominent role in resolving behavioral crises. Our calls nearly doubled since the initiation & may represent more awareness of the program and the prompt response rate of the CRT (less than 5 minutes). Preliminary results show significant amounts of missing data & point to the need for more investigation and analysis to determine if specific incident problems, diagnoses or skills of healthcare team resulted in documentation failure. We can now target awareness and specific skill training so patients can have a safer environment and health care providers feel more confident when these incidents occur.

P5-30
IDENTIFYING THE CRITICAL ELEMENTS OF ILLNESS MANAGEMENT AND RECOVERY: AN EXPERT SURVEY

Lead Author: Dominique A. White, B.A.

Co-Author(s): Alan B. McGuire, Ph.D.; Richard L. Roudebush; Michelle P. Salyers, Ph.D.

ABSTRACT:
Background: Illness Management and Recovery (IMR) is an evidence-based self-management program for people with severe mental illness. Extant research has indicated varied program implementation (Salyers, Rollins, McGuire, & Gearhart, 2009) and fidelity has been indicated in level of program effectiveness (Hasson-Ohayon, Roe, & Kravetz, 2007), necessitating strategies that support high fidelity implementation. Recently, a clinician-focused competence assessment, the IMR Treatment Integrity Scale (IT-IS), was created to assess fidelity of IMR implementation at the clinician level (McGuire et al., 2012). The current study reflects preliminary results of an expert survey aimed at assessing agreement regarding the critical elements of IMR and validating the IT-IS.

Methods: Published experts completed an online survey and were asked to refer clinical experts. Respondents rated 16 elements of IMR on three criteria: the essentialness of the element to the IMR model, the extent to which the element was defining of the IMR model, and the impact the element has on consumer outcomes. The degree to which each element on the IT-IS fidelity scale met these criteria was examined. Independent sample t-tests were used to compare differences between ratings from IMR providers and non-providers; ANOVAs were used to assess differences between researchers, clinicians, and respondents who engaged in both research and clinical practice, on ratings of the elements.

Results: A total of 73 experts completed the survey. Three items (Recovery Orientation, Goal Setting, and Structured Curriculum) met the strictest standard for criticality (i.e., mean >4.0 on all criteria). The remaining 13 items met a looser standard (i.e., mean >4.0 on at least one criterion). No item was identified for removal from the scale. The ratings on essentialness to model, defining of model, and impact on outcomes were averaged for each participant to create an overall rating of criticality for each of the 16 elements. Participants who provided IMR directly, rated Therapeutic Relationship, Structured Curriculum, and Coping Skills as more critical than those who do not provide IMR (t(69)=-3.77, p<.001; t(58)=-2.55, p=.013; t(56)=.-2.01, p=.049). Additionally, there was a significant difference between the 3 types of respondents for ratings of the element Therapeutic Relationship (F(2,56)=4.87, p=.01), with clinicians emphasizing the importance of Therapeutic Relationship (M=4.36, SD=.48) more than researchers (M=3.73, SD=.66); however respondents who engaged in both research and practice (M=4.11, SD=.59) did not significantly differ from the other groups.

Conclusions: These results provide valuable information which will be used to guide targeted implementation supports for Illness Management and Recovery.

P5-31
INVOLVEMENT, SATISFACTION AND TREATMENT ADHERENCE IN PEOPLE WITH SEVERE MENTAL ILLNESS

Lead Author: Malene Krogsgaard Bording, MSSc

Co-Author(s): Helle Østermark Sørensen; Bernd Puschner, Dr. phil. Dipl. Psych

ABSTRACT:
Introduction: Research on clinical decision making in health care has primarily focused on well-defined somatic illnesses. There is evidence in physical conditions that the quality of patient-clinician encounters is related to many positive health outcomes including increased satisfaction with care and better adherence to treatment regimes. However, little is known about the clinical decision making and outcome of people with mental illness and differences by kind of illness.

Objectives of the Study: To investigate the association between aspects of clinical decision making (involvement, satisfaction) on outcome (adherence) from patient and staff perspective with a special focus on diagnostic group as a moderator variable.

Methods: 588 participants in Ulm (DE), London (UK), Naples (IT), Debrecen (HU), Zurich (CH), and Aalborg (DK) gave informed consent to take part in the European multicenter study "CEDAR" which is a prospective observational study with bi-monthly assessments completed by both patients and staff during a one-year period. Aspects of clinical decision making (CDM) and adherence were measured by standardized instruments ("CDM Involvement and Satisfaction", "CDM in Routine Care").

Results: Patients rated involvement in CDM (active, shared, passive) more passively than professionals. These results did not differ by diagnosis (psychotic vs. affective disorders). Furthermore, adherence to treatment did not differ by diagnosis. Likewise, during the 1 year observation period, patient and staff ratings of satisfaction with CDM were similar.

Conclusions: Core aspects of clinical decision making (involvement and satisfaction) and a key outcome variable (adherence to treatment) do not differ for the most prevalent diagnostic groups among people with severe mental illness.

P5-32
QUALITY OF LIFE IN SCHIZOPHRENIA

Lead Author: Mariana Maris, M.D.

Co-Author(s): Florina Ra?oi, Delia Marina Podea

ABSTRACT:
Background: Interest in patient's social functioning with paranoid schizophrenia diagnosis has increased dramatically in recent years. Numerous quality of life assessment scales are investigating different areas, assessing basic daily needs: physical and mental health, health care, safety and security, food, housing, education, interpersonal ties, finances, activities, environment, dependence leisure, work, religion, related to personal experience.

Objectives: The aim of this study is to establish the influence of different variables like: age at onset, gender, residence area, education level, professional level, length of illness, pharmacological therapy on quality of life in subjects with paranoid schizophrenia.

Material and Methods: The study comprises a number of 100 subjects (50 without psychiatric diagnosis and 50 diagnosed with paranoid schizophenia according with DSM-IV-TR and ICD-10 criteria). For evaluation we used Quality of Life Rating Scale(QOL) and The Perceived Wellness Survey (PWS) which is a self application questionnaire.

Results: The results showed that most subjects diagnosed with paranoid schizophrenia have poor social functioning, but later onset of disorder is correlated with better social functioning. Women have higher scores on subscales of social employment or independence .

Conclusions: The study revealed that paranoid schizophrenia has poor social functioning. Females and later onset correlates with a higher social functioning.

Keywords: paranoid schizophrenia, gender, later onset, social functioning.

P5-33
SELF-REPORTED LEVELS OF ENGAGEMENT WITH FAMILY, FRIENDS, OR OTHERS BY PATIENTS WITH SCHIZOPHRENIA LIVING IN THE COMMUNITY

Co-Author(s): Lian Mao; Qin Li; Lynn Starr; John Fastenau; Michael Markowitz

ABSTRACT:
Objective: To describe levels of self-reported engagement with family, friends, or others by patients with schizophrenia living in the community.

Methods: The Research and Evaluation of Antipsychotic Treatment in Community Behavioral Health Organizations,

OUTcomes (REACH OUT) study is an ongoing, longitudinal, observational registry collecting information on patients with schizophrenia over 12 months. Patient engagement was assessed with a questionnaire consisting of two questions each on frequency of interactions, such as talking, emailing, or getting together, with either a family member, a friend, or others, such as with another person that was planned ahead of time or with someone considered more than a friend, like a spouse, a boyfriend, or a girlfriend. Responses to each question can be "not at all," which defined the not engaged cohort, or "once or twice," "about once a week," "several times a week," or "about every day" over the past 4 weeks, which defined the engaged cohort. Interim data reported at the study enrollment visit were analyzed. Predictors of each type of engagement were evaluated using multiple logistic regression analysis. Odds Ratios (OR) and their 95% Confidence Intervals (CI) were computed for the predictors. Explanatory variables included age, gender, race, ethnicity, education level, marital status, and living status. No adjustment was made for multiplicity.

Results: 812 patients were available for analysis. A majority were engaged with their family (88.3%), friends (73.8%), or others (65.9%). More than half (52.5%) of the patients were engaged across all three groups. Approximately two-thirds (67.1%) of patients were engaged with both family and friends; 60.6% were engaged with both family and others; and 56.7% were engaged with both friends and others. Patients engaged with family versus those not engaged were more likely younger (OR: 0.97, CI: 0.95-0.99) and more likely lived in private housing or an apartment (OR: 3.33, CI: 2.09-5.29). Patients engaged with friends were more likely to be non-Hispanic (OR: 1.96, CI: 1.31-2.92) and live in private housing or an apartment (OR: 1.52, CI: 1.06-2.16). Patients engaged with others were more likely younger (OR: 0.98, CI: 0.97-0.99), more likely non-Hispanic (OR: 1.98, CI: 1.35-2.91) and more likely female (OR: 1.65, CI: 1.17-2.33). Education level, race, and marital status were not found to be statistically significant predictors of engagement.

Conclusion: This analysis shows that the majority of patients with schizophrenia living in the community are engaged with their family, friends, or others. Patients who were younger, female, non-Hispanic, and lived in private housing or apartment tended to be more engaged.

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P5-34
ENGAGEMENT TRAJECTORIES IN COMMUNITY-BASED MENTAL HEALTH SERVICE DELIVERY: THE ROLE OF FINANCIAL INCENTIVES

Lead Author: Thomas McLean, M.Sc.

Co-Author(s): Ray Kotwicki, M.D., MPH; Philip D. Harvey, PhD

ABSTRACT:

Background: Previous literature notes that significant numbers of individuals with severe mental illnesses are often difficult to engage in treatment services. Non-engagement in community-based models of service delivery presents a major obstacle increasing risk for re-hospitalization/relapse. This is particularly important given the fact that many treatment interventions are limited in duration by insurance, meaning that immediate engagement may be required for optimal outcomes.

Methods: Skyland Trail's Milestones of Recovery Engagement Scale (SMORS) is an adaptation of the Milestones of Recovery Scale (MORS). This scale quantifies stages of recovery using range of milestones from complete disengagement to advanced recovery. The rating range from 1 to 6 and are generated by consensus between the primary counselor and treatment team reach. Patients who achieved a minimum threshold for a 4-week period were eligible for a financial incentive. All private pay families are eligible for financial assistance award. Patients must receive rating of 4.5 to "qualify" for assistance and consistently high ratings leads to increase amount of assistance (up to 20%). Change in ratings to less than 4.5 leads to lowering assistance amount.

Results: 423 cases had analyzable data. 78% of cases received a financial incentive. Of the cases who received an incentive, 94% sustained it over the course of treatment. Of cases without an initial incentive, only 20 cases improved in their engagement. Sustained engagement predicted positive discharge outcomes.

Implications: Individuals who demonstrated significant engagement in treatment received financial incentives. These individuals were very unlikely to lose those incentives over time. However, lower scorers showed minimal rates of increased engagement. Our interpretation of these results is that incentives can serve to sustain motivation of initially engaged cases with high levels of success, but there are a substantial proportion of cases where the provision of incentives does not lead to increased engagement. These cases likely require additional strategies to promote increased engagement in treatment.

P5-35
SUBJECTIVE QUALITY OF LIFE AND ITS DETERMINANTS IN A DUTCH CATCHMENT AREA-BASED POPULATION OF ELDERLY PATIENTS WITH SCHIZOPHRENIA

Lead Author: Paul D Meesters, M.D., Ph.D.

Co-Author(s): Hannie C Comijs, PhD; Lieuwe de Haan, M.D., PhD; Aartjan Beekman, M.D. PhD; Max L Stek, M.D. PhD

ABSTRACT:

Objective: Subjective quality of life (SQOL) is an established outcome measure in schizophrenia. In spite of the substantial proportion of elderly in the total schizophrenia population, evaluation of their SQOL and its determinants has been scarce and findings from epidemiological samples are lacking.

Methods: We evaluated SQOL in an epidemiological representative sample of elderly patients (n=107; mean age 68 years) with schizophrenia or schizoaffective disorder, aiming to include all individuals that were in contact with mental health services within a Dutch psychiatric catchment area. SQOL was assessed using the Manchester Short Assessment of Quality of Life (MANSA; Priebe et al., 1999). A number of demographic, clinical and social variables identified in the literature were evaluated for their impact on SQOL.

Results: The mean MANSA-score was 4.83, moderately surpassing the midpoint of this SQOL scale. Nearly half of all patients (47.7%) reported an overall favorable SQOL. Of the total variance in SQOL, clinical variables explained 50%, and social variables explained 16%, while demographic factors did not contribute. In multivariable analysis, less self-reported depressive symptoms, worse global cognition, and higher observer-based level of social functioning significantly predicted a higher SQOL, explaining 53% of the total variance.

Conclusion: Our study indicates that in late life schizophrenia depressed mood and social functioning are among the relevant predictors of SQOL. Depressive symptoms appear to be a more important source of distress than psychotic symptoms, on which treatment traditionally tends to focus. Pharmacological and/or psychosocial treatments for depression may prove fruitful for improving SQOL among this population. Next, psychosocial rehabilitation efforts can be promising starting points for targeting SQOL in elderly schizophrenia patients.

Reference: Priebe S, Huxley P, Knight S, Evans S, 1999. Application and results of the Manchester Short Assessment of Quality of Life (MANSA). Int J Soc Psychiatry 45, 7-12.

P5-36
FIRST EPISODE OF PSYCHOSIS: WHEN DO WE OBTAIN NEUROIMAGING?

Lead Author: Amita D. Mehta, M.D.

Co-Author(s): Gary Swanson, M.D.

ABSTRACT:

Introduction: A complete psychiatric assessment, including a medical and psychiatric history, physical examination, and mental status examination, must be conducted before the initiation of any clinical and diagnostic testing. That will guide the clinician their choices for relevant, cost-effective laboratory testing. Laboratory costs accounted for 10%–12% of total health care costs. Psychotic manifestations are rare, but it can be the presenting features of intra-cranial tumours. This Case help us decide when should we obtain neuroimaging, is it cost effective, how many psychiatrist/ER physician follow this protocol?

Case: A 60-year-old African American female with history of seizure disorder & no past psychiatric history, was brought to the hospital on 302 commitment petitioned by landlord for paranoid behavior of last 30days. Her physical exam and routine laboratory workup was normal except CT scan : Ventriculomegaly, Hydrocephalus & Multiple hyperdensities within the right temporal region. Follow up MRI : includes ganglioma, oligodendroglioma. Patient was admitted under Neurolosurgical service and appropriate treatment was given.

Study: IRB approved research was conducted by calling/emailing Allegheny county mental health unit department chairman. 71% said they follow APA guideline of performing neuroimaging in first episode of Psychosis but no institute finds this test to be cost-effective

Conclusion: More extensive laboratory screening may be required for several categories of patients: elderly individuals, institutionalized persons, persons of low socioeconomic status, individuals with a high degree of self-neglect, persons with alcohol or drug dependence, and those with cognitive impairment or fluctuating mental status. These patients may be less able to give a coherent or complete clinical history, or to have higher burden of complex medical illnesses, and thus require more "detective" work in the form of laboratory workup.

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(3) What Investigations Are Ordered in Patients with First-episode Psychosis? Allan Shefrin, M.D. (PGY2), Derek Puddester, M.D., Stephanie Greenham, Ph.D.,Lise Bisnaire, Ph.D., Hazen Gandy, M.D.

P5-37
ELECTRICAL THRESHOLD FOR SEIZURES DURING BILATERAL ELECTROCONVULSIVE THERAPY: THE

EFFECTS OF AGE AND ANTICONVULSANT MEDICATIONS

Lead Author: Abhishek R. Nitturkar, M.B.B.S.

Co-Author(s): Jagadisha Thirthalli; Shashidhara N Harihara; Virupakshappa I Bagewadi; Shubhangi S Mathpati Divyasree S; Naveen Kumar C Bangalore N Gangadhar

ABSTRACT:
Background: The efficacy and adverse effects of electroconvulsive therapy (ECT) depends on the amount by which the electrical dose exceeds individual patients' seizure threshold. Titration method is arguably the commonest method of assessing seizure threshold. Formula-based methods use age as the most important predictor of seizure threshold. The effect of anticonvulsants (AC) in determining the seizure threshold has been sparsely studied

Method: ECT records of 521 patients who received bilateral ECT (BLECT) in one calendar year in National Institute of Mental Health and Neurosciences (NIMHANS) were studied. Their demographic, clinical and ECT details were recorded. At NIMHANS, during the first ECT session, seizure threshold is determined by titration method, starting with 30 milli-Coulombs (mC) and increasing in steps of 60mC till generalized seizure is induced. We compared the percentage of patients above and below 40 years of age with different seizure thresholds.

Results: Among those <40 years of age, 330 of 427 (77%) had seizure threshold >120mC; nearly all (90 of 94; 96%) of those over 40 years of age had the threshold >120mC (OR=9; 95% CI=2.127 – 38.1). The figures were similar irrespective whether they were on AC or BZPs or both.

Conclusions: While using titration method of determining seizure threshold with BLECT for those above 40 years of age, one may start at 120mC. This would avoid repeated stimulations at lower doses and chances of failure to elicit seizures during the first session of BLECT. The risk of using higher stimulus dose is about 4% with this approach.

P5-38
TOPIRAMATE REDUCES CRAVINGS IN A COCAINE DEPENDENT PATIENT: A CASE REPORT

Lead Author: Michael Olla, M.D.

Co-Author(s): Manoj Puthiyathu, M.D; A. Hussain, M.D.; Samrah Waseeem, M.D.; Bharat Nandu, M.D.; Jose Bravo; Onyechi Aginah, M.D.

ABSTRACT:
This report highlights the reduction of cravings in a patient with a twenty- five year history of Cocaine Dependence, who has been prescribed topiramate. Currently, there is no pharmacological treatment approved to reduce cravings in Cocaine Dependence. Newer studies have revealed topiramate to exercise its anticraving action and abstinence through an increase in the GABAergic neurotransmission and inhibition of AMPA/ kainite receptor activity1. Topiramate had been initially used as an anticonvulsant, approved for migraine prophylaxis, and also prescribed for bipolar and post- traumatic stress disorders2.

We present a 48 year- old male who showed an evident reduction of cravings and a decreased time between relapses from cocaine usage. To determine if there was a salient reason for this desired result, a more detailed history of his lifestyle and recent modifications was obtained. The initiation of topiramate was the only noticeable difference in the patient's treatment plan. With the gradual increase in the dosage of the mood stabilizer, the patient's cravings for cocaine lessened.

There is a need for an increased awareness of the likelihood that topiramate may enhance the anti-craving effect and increased sobriety from cocaine

P5-39
HEALTH SCREENING, COUNSELING, AND HYPERTENSION CONTROL FOR PEOPLE WITH SERIOUS MENTAL ILLNESS IN PRIMARY CARE

Lead Author: Sharat Parameswaran, M.D.

Co-Author(s): Alexander Young, M.D.

ABSTRACT:
People with serious mental illness (SMI) have higher rates of mortality than the general population, attributable primarily to chronic medical conditions, and due potentially in part to poorer quality primary care assessment and management. The purpose of this study was to use a U.S.-representative sample of consumers to determine if people with SMI presenting to primary care providers have different rates of basic physical health assessment and management compared to the general population, and to determine factors associated with differing rates of these measures. This cross-sectional analysis used visit-level outpatient data from 2005 to 2010 for consumers age 16 or older from two annual surveys, the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. Weighted logistic regressions were performed adjusting for patient demographics, comorbidity, reason for visit, number of prior visits, any antipsychotic medication use, practice characteristics, insurance status, and year of survey. Dependent variables were provision of health counseling, blood pressure or weight measurement, and elevated blood pressure with a diagnosis of hypertension, during a visit. The primary predictor was diagnosis of SMI, including an interaction with years after 2005. No significant effect of SMI diagnosis on receiving health counseling, weight assessment, or hypertension control was found in weighted adjusted models. Relative to others, the likelihood of blood pressure measurement at a visit in people with SMI increased from 2005 to 2010 (OR=0.117 in 2005, OR= 3.28 in 2010), and the predicted probability of blood pressure assessment in people with SMI increased from 67.2% to 96.9%. Within the sample of people with SMI diagnoses, compared with Medicare, people were less likely to receive health counseling if they had Medicaid, and compared to visits at nongovnermental institutional settings, visits were less likely to include health counseling if they were at private practice or government clinics. Compared to those with no prior visits, people with SMI had higher odds of receiving health counseling (OR=5.58) and lower odds of uncontrolled hypertension (OR=0.072) if they had 6 or more visits in the last year. This study uniquely demonstrated that although people with SMI at primary care visits were less likely to receive blood pressure screening than others in 2005, this disparity reversed by 2010; a better understanding of the mechanism of this change may help improve future intervention strategies. Findings of improved health counseling and hypertension control with higher visit frequency suggests that future work should directly investigate if increasing primary care visit frequency improves physical health care delivery for people with SMI.. Future work will also benefit from prospective or experimental studies to better understand these findings.

P5-40
DEPRESSION: A COMPLICATION OF CEREBRAL ANEURYSM REPAIR

Lead Author: Muhammad Puri, M.D., M.P.H.

Co-Author(s): Nazish Hafeez, M.D.

ABSTRACT:
The purpose of this case report is to present mood disorder, specifically depression in a patient status post-surgical repair of a cerebral aneurysm.

A 57 year old female presented with depression and suicidal ideation. Her past medical history includes an anterior communicating artery aneurysm and a repair of an anterior cerebral artery aneurysm four years prior. She has been diagnosed with and is being treated for depression since the last two years.

At present there are cases and research documenting cognitive impairments in patients undergoing surgical repair of cerebral aneurysms. However the onset of depression in this subset of patients is not well documented as the cognitive impairments. Our focus is to look at depression arising due to structural damage in patients who have undergone surgical repair of cerebral aneurysm.

P5-41
THE ROLE OF MEMANTINE IN THE TREATMENT OF PSYCHIATRIC DISORDERS OTHER THAN THE DEMENTIAS

Lead Author: Muhammad Puri, M.D., M.P.H.

Co-Author(s): Fauzia Syed M.D., Anthony Vasilov M.D., Yerupa Reddy M.D., Kush Patel, M.D., Akbar, M.D.

ABSTRACT:
Memantine is a non-competitve NMDA receptor antagonist, but, at variance with the most potent NMDA receptor blockers, such as Ketamine, Phencyclidine and MK-801, has a low affinity for the receptor and its action is voltage/use dependent (Gillin et al., 2009; Johnson & Kotermanski, 2006; Rammes et al., 2008) . Moreover it has been recently demonstrated that this compound selectively blocks the extrasynaptic (excitotoxic) receptor but preserves the normal synaptic function (La Spada, 2009). These peculiar pharmacological properties explain the lack of psychotomimetic/psychedelic effect and of interference with the normal physiological functions [memory and learning, synaptic plasticity, etc. etc. (Van Dongen, Editor, 2009)].

Memantine is increasingly being studied in a variety of non-dementia psychiatric disorders. This paper is aimed to critically review relevant literature on the use of the drug in animal models of psychiatric disorders and its effects in human studies of specific psychiatric disorders. A recent preclinical and clinical finding suggests that add-on Memantine may show antimanic and mood-stabilizing effects in treatment-resistant bipolar disorder.

P5-42
POST-ICTAL EEG SUPPRESSION DURING EARLY COURSE OF ECT PREDICTS CLINICAL IMPROVEMENT IN BIPOLAR DISORDER

Lead Author: Gopalkumar Rakesh, M.B.B.S., M.D.

Co-Author(s): Dr BN Gangadhar; Dr Jagadisha Thirthalli; Dr C Naveen Kumar; Dr Muralidharan Keshavan; Mr Vittal Candade

ABSTRACT:
The extent of post-ictal suppression of electroencephalography (EEG) of electroconvulsive therapy (ECT)-induced seizures is known to predict antidepressant response to ECT. In this study we examined the association between the post-ictal EEG suppression and response to ECT.The sample for this study came from a randomized controlled trial examining the effect of co-prescription of anticonvulsant mood stabilizers during ECT. The sample comprised 48 patients randomized to three groups with stopping, halving or continuation of anticonvulsant mood stabilizer medica-

tions. EEG recording of the second or third ECT session was analyzed using a standard algorithm to measure fractal dimension (FD) as a measure of amplitude. Clinical improvement was assessed using Clinical Global Impression (CGI) severity scale. There was a significant inverse correlation between post-ictal FD and improvement in CGI severity scale scores. (Spearman's Rho = 0.471, p=0.034).

P5-43
ANTIPSYCHOTIC USE IN PATIENTS WITH DELIRIUM IN A TERTIARY CARE SETTING

Lead Author: Swapnil Rath, M.B.B.S.

Co-Author(s): R Mason, R Rajab-Ali, A Edstrom, A Mayorga May, T Long, D Swagerty

ABSTRACT:
Background: Delirium is a common and often overlooked disorder of cognition that is associated with increased morbidity and mortality. As there is little information in the literature regarding quality improvement for delirium care in the non-ICU setting, our goal was to design interventions to improve the prevention, diagnosis, and management of delirium in non-ICU patients.

Methods: A Delirium Task Force was formed at the University of Kansas Hospital consisting of psychiatrists, geriatricians, a pharmacist, and multiple members in nursing leadership. As early intervention is correlated with the most favorable outcomes, we aimed to evaluate the use of antipsychotics in the management of delirium. We chose patients receiving constant observation (1:1 staff ratio) as a surrogate marker of patients with delirium and evaluated the use of antipsychotics the day of constant observation initiation. We excluded those who did not have delirium by the Confusion Assessment Method assessment or who had alcohol withdrawal.

Results: 27 patients were identified during the data collection period. Median age was 65. Of 27 patients, 15 (56%) were given an antipsychotic, but only 9 (33%) were on a scheduled dose of antipsychotic. There was also a high incidence of delirium provoking medications (63%), mainly benzodiazepines.

Conclusion: Treatment guidelines for delirium advocate commencing antipsychotics at low doses with judicious titration upwards. To this effect, we have developed a delirium order set to prompt medication review and appropriate pharmacotherapy. Another set of interventions involve educating nurses and physicians. We plan to reassess and report our findings when the interventions are complete.

P5-44
IMPROVING THE QUALITY OF THE MEDICATION RECONCILIATION PROCESS IN PSYCHIATRY

Lead Author: Anetta Raysin, D.O.

Co-Author(s): Scot G. McAfee M.D., Vivian Fernandez, Theresa Jacob PhD, MPH

ABSTRACT:
Background: Patient safety is the cornerstone of quality care among all medical specialties and institutions nationwide. Given the significance of documentation in the care provided, the Committee of Interns and Residents and the Joint Quality Improvement Committee along with hospital administration at Maimonides Medical Center developed a medication reconciliation project, carried out by resident physicians in the academic medical center. Medication reconciliation is the process of maintaining an accurate list of patients' medications from the time of admission and ensuring that discharge medications reflect their hospital course.

Objective: To improve the accuracy of the medication reconciliation process performed at the time of discharge while meeting target improvement rates during four review periods. Additionally, the project emphasizes peer education and collaboration in learning how to accurately complete the reconciliation for every patient admitted to the inpatient services.

Method: A series of chart reviews established the baseline accuracy of the existing reconciliations and set up target percentages for improvement. A checklist with requirements for the determination of a fully completed and accurate reconciliation was made. This was used in conjunction with other efforts as a means of peer education; for example, "super-users" providing one-on-one assistance on the units, chief residents giving reviews during meetings, and introducing new house staff to the process at the time of orientation. The chart review methodology was distributed to residents who volunteered to participate in the subsequent audit. At this time, the psychiatric discharge summaries were used to identify discharge medications and were compared with the computer medication list to ensure that they were identical, while charting whether individual charts "passed" or "failed." These statistics were later reviewed to determine if there was an improvement in the reconciliation process in comparison to baseline metrics and whether the target goal was met.

Results: Overall, the results improved compared to baseline although multiple challenges were encountered. Despite the first chart review improvements where results exceeded the target, the second chart review results were below the target goal. Most likely this occurred due to a systems issue in psychiatry where half of the interns switch from Medicine to Psychiatry in January. This reinforced that it is crucial to provide additional training during mid year crossover.

Conclusions: Patient safety is a mutual goal of hospital administration and house staff working on a daily basis to ensure that every patient is provided proper care. As a result of this project, there was an increase in resident engagement, a reduction of flaws in the reconciliation process, and an increase in education regarding patient safety and goals for future improvement in subsequent chart reviews.

P5-45
HIGH EMERGENCY SERVICE UTILIZATION AMONG OLDER ADULTS WITH SERIOUS MENTAL ILLNESS

Lead Author: Stephanie Alexia Rolin, M.P.H., M.D. Candidate

Co-Author(s): Stephen J. Bartels, M.D., MS; Kelly Aschbrenner, PhD; Sarah Pratt, PhD

ABSTRACT:
Context: Over 6 million older adults in the United States suffer from a serious mental illness (SMI), such as schizophrenia or bipolar disorder. This population is at high-risk of requiring emergency services, leading to estimates of per-person health care costs that are nearly 50-200% higher than the general population. As the population of adults with SMI ages, the projected cost of caring for these individuals is increasing exponentially.

Objective: To understand risk factors associated with high emergency service utilization in older adults with SMI.

Design & Setting: Cross-sectional survey of 180 older adults (> 50 years old) with SMI (schizoaffective/schizophrenia; bipolar disorder; or depression). Emergency service utilization determined by chart review of services received in the previous 12 months.

Main Outcome Measures: High emergency service utilization, as defined by 3 or more visits to the emergency department in the past year.

Results: 26% of the sample consisted of frequent users of emergency services. Individuals who utilized the emergency department more often had higher Charlson severity index scores (2.28 vs. 3.70, p=0.0003). There were no differences in age, sex, or psychiatric diagnoses between these 2 groups. In a multiple logistic regression model, primary psychiatric diagnosis of an affective disorder was associated with a higher odds of frequently visiting the emergency department (OR 3.01, p=0.03) compared to a reference group with schizophrenia/schizoaffective disorder. Additionally, in this model, individuals with higher general health scores on the SF-36 (above 50 vs. less than 50) had lower odds of being frequent utilizers of the emergency department (OR 0.44, p=0.03). Those with higher Charlson severity index scores had higher odds of utilizing the emergency department (p<0.001 for test of trends).

Limitations: The study population consisted of 180 older adults with SMI in New Hampshire, which limits the generalizability of the results to other groups such as younger adults with SMI or other geographical regions.

Conclusions: This study presents risk factors for high emergency department utilization in older adults with SMI, which is important as understanding these risk factors may help target needed preventative services in order to promote health and reduce costs.

P5-46
ALTERNATIVE PSYCHOSIS AND TEMPORAL LOBE EPILEPSY: A CASE REPORT

Lead Author: Gurjot Singh, M.D.

Co-Author(s): S.Yerrapureddy M.D; S. Riaz M.D.; Iffath Hussain MSIII, Ravi Shah MSIII, Max Hockstein MSIII, Nida Naqvi MSIII

ABSTRACT:
Background: There is high evidence of association between temporal lobe epilepsy (TLE) and psychosis (1,3). Psychosis due to epilepsy is currently categorized as ictal, postictal, interictal, or chronic schizophrenia like psychosis based on their association with seizure episodes.1 Epilepsy associated psychosis mostly resolves in days or weeks but there are some 1% of cases where psychosis worsens with improvement in seizure episodes.7 This kind of relationship was described by Landolt as "forced normalization" or clinically now known as "Alternative Psychosis" (1, 6). We herein report a case of Alternative psychosis that developed after TLE.

Case Report: AJ was a 14 year old African American female, single, living with her biological mother, 8th grade special school, born prematurely at 25 weeks, and was admitted in our hospital for aggressive-combative behavior and worsening of auditory hallucinations. The patient has a significant past history of TLE diagnosed 2 years ago when she developed her first episode of generalized seizures. Psychiatry was consulted 2 weeks later for her symptoms of aggression with no relation to ictal or post ictal phase. There was no prior psychiatric history before the first episode of seizure. She was given an Axis 1 diagnosis of 'Psychosis due to General Medical Condition'. After 2 years of follow up, her seizure episodes improved but her psychotic symptoms worsened. There were multiple inpatient psychiatric admissions for increased combative behavior and worsening of auditory hallucinations during this 2 year period. Repeat EEGs were normal and MRI done showed no neuropathology. Her medications included Phenytoin 100 mg PO TID,

Oxcarbazepine 300 mg 3 tablets PO BID, Aripiprazole 10 mg PO QD, clonazepam 0.5 mg PO BID, Quetiapine 100 mg PO QD. She was compliant with the treatment but her worsening psychosis is a concern. Modification of her treatment regimen is planned.

Discussion: This case of a 14 year old patient developing psychosis after TLE is an excellent example of the established relationship between epilepsy and psychosis. This case highlights the concept of Alternative psychosis, where patient's seizure episodes improved with adequate anti-epileptic drugs, but the psychotic state worsened (1). Treating psychosis associated with epilepsy is a challenge, as several antipsychotics can lower seizure threshold and can worsen the epilepsy. Also, some anti-epileptics can cause psychosis due to their rare but major side effect. This demands a balanced, careful and strategic treatment plan using antipsychotics with low epileptic properties like olanzapine, risperidone and Quetiapine (7). Drugs like Clozapine and Chlorpromazine should be avoided. Some studies recommend reduction or discontinuation of anti-epileptic drugs to improve psychosis (7). The prognosis of this kind of case with alternative psychosis is always a major concern for psychiatrists due to limited research.

P5-47
CASE REPORT: PROLONGED DELIRIUM AFTER OLANZAPINE PAMOATE INJECTION, CONSEQUENCE OF PRO-INFLAMMATORY CYTOKINE SECRETION?

Lead Author: Thomas Sobanski, M.D.

Co-Author(s): Berit Wenda, M.D. - Ilko Dafov, M.D. - Gerd Wagner, PhD

ABSTRACT:
Introduction: Post-injection delirium/sedation syndrome (PDSS) occurs in approximately 0.07% of olanzapine pamoate injections (1.4% of all treated patients). PDSS presents with symptoms similar to olanzapine overdose: e.g. sedation, confusion, unconsciousness, slurred speech, and altered gait. Symptom onset ranges from immediate to 5 hours post injection. Patients tend to recover within 24 to 72 hours. We report a patient who developed severe and prolonged delirium subsequently to olanzapine pamoate administration.

Case report: This 54 year-old patient had suffered from schizophrenia for 14 years. Due to side effects therapy was switched from flupentixol decanoate to oral olanzapine and subsequently to olanzapine long-acting injection (OLAI) treatment. Hereafter positive and negative symptoms as well as the patient`s adherence to therapy improved significantly. OLAI treatment was well tolerated. The patient had no history of severe somatic disease (weight: 163 lb, height: 6 ft, 1.2 in, BMI: 21.4). When the 7th olanzapine injection was given (after 3.5 months of OLAI treatment) the patient developed PDSS, in spite of proper injection technique being used. First symptoms were slurred speech, ataxia, visual hallucinations, and hyperhidrosis. After two hours psychopathology had progressed to full-blown delirium including clouding of consciousness, disorientation, agitation and tachycardia (145 bpm). When the patient was admitted to our ward stomatitis, pharyngitis and bronchitis were diagnosed (leucocyte ratio: 12 Gpt/l; 19 Gpt/l after 48 hours. C-reactive protein: 18 mg/l; 179 mg/l after 48 hours). Due to antibiotic therapy (ampicillin/sulbactam) and psychotropic treatment (haloperidol, diazepam) the infection as well as the symptoms of delirium started to improve after five days. After two weeks leucocyte ratios and C-reactive protein were normal. Nevertheless, electroencephalography still revealed signs of altered brain function (widespread 4/5-theta-activity) at that point. At the time of discharge (after 23 days) a restitutio ad integrum had been achieved, and OLAI therapy was continued later due to the given individual benefit.

Discussion: In the reported case PDSS progressed to severe delirium. In our opinion delirium was caused by the increased plasma concentrations of olanzapine as well as by the serious infection. The prolonged course of the syndrome may also have been due to the fact that pro-inflammatory cytokines (e.g. TNF-alpha, IL-1beta) suppress the activity of the hepatic cytochrome P-450 isoencyme CYP1A1, which is a major pathway of olanzapine metabolism. C-reactive protein, which was closely monitored in our patient, revealed a peak-like pro-inflammatory cytokine response.

Conclusions: As this case shows, PDSS may convert to full-blown delirium if a severe infection is present. In these patients a transient switch from OLAI to oral olanzapine therapy may be considered to reduce the risk of harmful outcome.

P5-48
CHARACTERIZATION OF SUBJECTS WITH SCHIZOPHRENIA AND CRIMINAL JUSTICE SYSTEM INVOLVEMENT FROM AN ONGOING CLINICAL TRIAL

Lead Author: H. Lynn Starr, M.D., FAAP

Co-Author(s): Cynthia A. Bossie, Joe Hulihan, Lian Mao, Larry Alphs

ABSTRACT:
Introduction: Overrepresentation of people with serious mental illness (SMI) in the US criminal justice system (CJS) is an important public health concern. A recent analysis of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study identified risk factors for CJS involvement among schizophrenia subjects during that trial as younger age, male sex, adolescent conduct disorder diagnosis, symptoms of akathisia, and drug abuse (Greenberg et al, Community Ment Health J 2011;47:727–736). The current analysis characterizes the population enrolled in an ongoing prospective study of schizophrenia subjects recently involved with the CJS and compares the prevalence of these risk factors and other variables with those from the CATIE study.

Methods: Paliperidone Research in Demonstrating Effectiveness (PRIDE; NCT01157351) is an ongoing, 15-month, randomized, open-label, rater-blinded, parallel-group, multicenter US study comparing paliperidone palmitate with oral antipsychotics in a community sample of subjects with schizophrenia recently released from incarceration. Descriptive statistics were used to summarize baseline demographics and clinical characteristics of subjects enrolled (as of 8/21/12) in PRIDE. These data were compared with published results from the overall CATIE population (Lieberman et al, N Engl J Med 2005;353:1209–1223 and Miller et al, Br J Psychiatry 2008;193:279–288).

Results: Corresponding baseline data were available for several variables in both PRIDE (n=413) and CATIE (n=1460). Data for potential risk factors for CJS involvement identified by Greenberg et al were (PRIDE vs CATIE):

1. Mean (SD) age: 38.0 (10.5) vs 40.6 (11.1) years

2. Male sex: 87.1% vs 74.0%

3. Akathisia: 16.8% (via ESRS-A scale) vs 19.9% (via BARS scale)

4. Substance abuse (alcohol and drug combined): 54.4% (via ASI-LITE) vs 37.2% (via Swartz et al, Psychiatr Serv 2006;57:1110–1116)

5. Adolescent conduct disorder diagnosis was not available from PRIDE

Other variables for which data were available (PRIDE vs CATIE) included:

1. African American: 62.6% vs 35.1%

2. Mean (SD) age at first treatment for behavioral/emotional problems: 20.7 (7.4) vs 24.0 (8.9) years

3. Mean (SD) length of illness: 16.8 (10.1) vs 14.4 (10.7) years

4. Mean (SD) CGI-S score: 3.8 (0.8) vs 4.0 (0.9)

5. Percent unemployed: 86.9% vs 84.9%

Conclusion: Data suggest differences in several baseline characteristics between schizophrenia subjects identified in a study evaluating recently incarcerated schizophrenic persons and those identified through a more general study of persons with schizophrenia. These findings help characterize clinical and phenotypic features associated with CJS involvement among persons with schizophrenia.

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P5-49
IDENTIFYING BARRIERS TO THE USE OF CLOZAPINE FOR SCHIZOPHRENIA

Lead Author: Veronika M. Stock, M.D.

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ABSTRACT:
Background: Clozapine is the only antipsychotic medication proven effective, approved for, and recommended for treatment-resistant schizophrenia. Despite these recommendations, prescription of clozapine in the United States is infrequent and disproportionately low relative to the estimated prevalence of treatment-resistant schizophrenia. More appropriate prescribing of clozapine could lead to improvements in outcomes. Recent studies provide convincing evidence that a significant barrier to treatment involves knowledge gaps on the part of the treating psychiatrist including lack of knowledge about clozapine efficacy and overestimation of side effects.

Methods/Design: We will examine and quantify barriers to clozapine prescribing by physicians and the relative perceived weight of various barriers using an anonymous paper-and-pencil or web-based survey. Additionally, we will examine an association of physician characteristics with clozapine prescribing practices. The survey is designed as a multiple-choice, 56-item questionnaire which will be distributed primarily to psychiatry residents and psychiatrists from various inpatient, outpatient, and community psychiatry groups in the State of Maryland. We will select approximately 900 potential participants in order to get a 25-30% anticipated response (approximately N=225-270 or more). Participants will be asked to rate the importance of several potential barriers to clozapine prescribing, including clinical, non-clinical (administrative), and side effects related barriers. Possible interventions to improve utilization of clozapine will be suggested and participants will have an opportunity to rate and comment on them.

Clinical Implications: A recent editorial states that the "suboptimal use of clozapine is currently one of the more serious problems in the treatment and science of schizophrenia that needs to be addressed." Once barriers are iden-

tified and quantified, an intervention to improve clozapine knowledge and prescribing practices can be designed. There is reason to expect that an appropriate, efficient and well-crafted intervention could lead to the enhanced prescribing of clozapine and improved outcomes in individuals who receive this treatment. Some evidence suggests that interventions such as educational interventions, guideline implementation and academic detailing are effective in changing prescribing behavior.

P5-50
PSYCHIATRIC DISORDERS IN 22Q11.2 DELETION SYNDROME ARE PREVALENT BUT UNDERTREATED

Lead Author: Sunny Xiaojing Tang, A.B.

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ABSTRACT:
Background: Chromosome 22q11.2 deletion syndrome (22q11DS) is a common genetic disorder with high rates of psychosis and other psychopathologies, but few studies discuss treatment. Our goal is to characterize the burden and treatment of major psychiatric illnesses.

Methods: This is a prospective cross-sectional study of 112 individuals aged 8 to 45 with a confirmed diagnosis of 22q11DS. Each participant was administered a modified Kiddie-Schedule for Affective Disorders and Schizophrenia for School-age Children and the Structured Interview for Prodromal Syndromes. Phenotypes assessed were threshold and subthreshold psychosis, depression, mania, generalized and separation anxiety, obsessions/compulsions, inattention/hyperactivity, and substance use. History of mental health care and current psychotropic treatment were obtained.

Results: Psychopathology was common, affecting 79% of individuals; a high burden of three or more diagnoses was most common in young adults aged 18-24 (41%). Many met criteria for psychosis (11%), attenuated positive symptom syndrome (APS, 21%), or experienced significant subthreshold symptoms (47%). Peak occurrence of psychosis risk was during adolescence (12-18yrs). Twenty percent were diagnosed with a mood disorder, 35% anxiety disorder, 32% ADHD, and 2% substance-related disorders. Sixty-three percent received mental health care in their lifetime, but few continued therapy (40%) or used psychotropics (39%). Antipsychotics were used by only 42% of psychotic participants and none of the participants with APS. Half of those with APS or psychosis were receiving no mental health care.

Conclusions: Psychopathology is common in 22q11DS, but is not adequately treated or clinically followed. Particular attention should be paid to subthreshold psychotic symptoms, especially in adolescents.

P5-53
ANTIPSYCHOTIC USE PERSISTENCE PATTERNS IN PATIENTS WITH SCHIZOPHRENIA: POLYPHARMACY VERSUS MONOTHERAPY

Lead Author: Maxine Fisher, M.D.

Co-Author(s): Kathleen Reilly, MS; Keith Isenberg, M.D.; Kathleen F. Villa, MS

ABSTRACT:
Objective: To characterize real-world patterns of persistence in patients with schizophrenia treated with antipsychotic (AP) monotherapy vs. patients treated with antipsychotic (AP) polypharmacy.

Methods: We examined commercial claims from 01/01/2007-04/30/2010 using the HealthCore Integrated Research Database. Patients (N=4,156) 13-64 years old with ? 2 claims for schizophrenia and treated with AP medications (2nd generation and/or 1st generation) were identified and followed for 1 year. Therapy groups were categorized as: AP monotherapy (1 antipsychotic: N=3,188; 77%) and AP polypharmacy (2+ antipsychotics: N=968; 23%). Persistence was defined as: (1) length of therapy (days without a 90-day gap in treatment) and (2) percent discontinuing by 3, 6 and 12 months (defined as a ?90 day gap in treatment of at least one AP). Measures were described as means and standard deviations for continuous variables and frequencies for categorical variables. Differences in mean length of therapy were compared using t-tests, and Chi-square tests were used to compare proportions of patients discontinuing. Logistic regression analyses were used to predict discontinuation before 12 months and OLS regressions to predict length of therapy by type of therapy controlling for gender, region, number of somatic and psychiatric comorbidities, Deyo-Charlson comorbidity score, and number of psychiatric and somatic medications.

Results: The majority of patients discontinued the AP they were taking at the start of the study period prior to the end of the one-year follow-up (77% of AP polypharmacy patients vs. 53% of AP monotherapy patients). 50% of AP polypharmacy patients discontinued their AP regimen (1 or more APs) prior to 3 months compared to 17% of AP monotherapy patients. The average length of therapy was 170±168.3 days and 253±147.4 days for AP polypharmacy and AP monotherapy patients, respectively (p<0.01). Similarly, 69% (N=425) of AP monotherapy patients under 26 (N=619) discontinued by 12 months compared to 47% of AP monotherapy patients over age 45 (N=614). Among AP polypharmacy patients, 88% of patients under 26 discontinued prior to 1 year and 72% of patients over age 45 discontinued. In multiple regression, both age and use of AP polypharmacy were independent predictors of length of therapy and discontinuation by 12 months. In addition, having ? 3 additional psychiatric medications was associated with shorter duration of therapy (-13 days, p<0.01).

Conclusion: Persistence with AP therapy is low among all patients, especially among younger patients and patients on polypharmacy (combinations of 2nd and/or 1st generation APs). Differences in continuance by age and type of therapy may be due to differences in disease severity requiring greater efforts to identify optimal treatment, as well as reduced insight that leads to lower adherence.

P5-54
TOLERABILITY AND COSTS ASSOCIATED WITH ANTIPSYCHOTIC (AP) MONOTHERAPY VERSUS (AP) POLYPHARMACY

Lead Author: Maxine Fisher, M.D., Ph.D.

Co-Author(s): Keith Isenberg, M.D.; Kathleen F. Villa, MS

ABSTRACT:
Objective: To compare total healthcare cost, inpatient utilization and comorbidities among patients with schizophrenia (SZ) taking antipsychotic (AP) monotherapy versus those taking AP polypharmacy.

Methods: We examined a retrospective cohort from commercial claims from 01/01/2007-04/30/2010 using the HealthCore Integrated Research Database (HIRDsm). Patients (N=4,156) between ages 13-64 with ? 2 claims for SZ were identified and indexed based on the first medical claim for SZ in the study period. AP use at baseline (2nd and/or 1st generation APs) was identified by the pharmacy claim closest to the index medical claim within 180 days. Patients were followed for 1 year. AP therapy group was categorized as: AP monotherapy ("mono"; one AP: n=3,188, 77%) or AP polypharmacy ("poly"; two or more APs filled within 45 days: n=968, 23%). Total annual costs of all medical and pharmacy claims were calculated. Costs were described with means and standard deviations. Differences in mean costs were compared using ANOVAs (using log transformed values). Types and numbers of comorbidities and medications were described as well as patient demographic and treatment characteristics. GLM regressions were used to predict total costs by type of therapy holding the above covariates constant.

Results: Compared to patients on mono, poly patients had significantly higher (p<0.01) mean total annual all-cause costs (mono: $19,319±30,287 vs poly: $31,264±39,869) and higher (p<0.01) mean total annual costs even when excluding APs (mono: $16,316±30,165 vs poly: $25,550±39,999). Inpatient services were the main driver, accounting for 39% of annual costs among mono patients and 45% among poly patients. Compared to mono patients, more poly patients had at least 1 inpatient stay (mono: 32% [n=1027] vs poly: 50% [n=480]) and nearly double the rate of re-admissions (mono: 14% [n=436] vs poly: 23% [n=222]). Poly patients had nearly double the frequency of obesity in every age group compared to mono patients (p<0.01) and higher rates of hyperlipidemia (p<0.05) and diabetes (p<0.05) among patients 18-45. In regression analyses predicting costs controlling for age, gender, somatic medications and comorbidities, psychiatric medications and comorbidities, length of therapy, and switch in AP, poly was an independent predictor of total annual all cause costs (p<0.01) and total annual costs excluding costs of index medications (p<0.01). Higher comorbidity burden was also significantly associated with higher costs. (p<0.01)

Conclusion: Patients on poly (multiple 2nd and/or 1st generation APs) seem to have more severe SZ, which could account for differences in cost and inpatient utilization. However, the higher rate of re-admission (more than 1 inpatient stay) among poly patients suggests poly may have limited efficacy and needs to be weighed against the comorbidity and cost burdens.

POSTER SESSION 6

P6-01
ENGAGEMENT OF SUICIDAL PATIENTS IN TREATMENT: THE IMPACT OF AN EMERGENCY DEPARTMENT-BASED INTERVENTION IN NIGERIA

Lead Author: Increase Ibukun Adeosun, M.B.B.S., FWACP

Co-Author(s): Dr. Abosede Adekeji Adegbohun, M.B.,B.S, MWACP

ABSTRACT:
Introduction: Globally, over a million lives are lost to suicide annually. Though reliable national statistics are lacking, available data suggest that the rates of suicide in Nigeria may be comparable to global patterns. Engagement of patients who have contemplated or attempted suicide in treatment could reduce their risk of recidivism and completed suicide. The Emergency Department (ED) has been identified as a thoroughfare for suicidal patients; it is therefore a strategic site for implementing interventions targeted at engaging suicidal patients in treatment. Literature search revealed scarcity of data on interventions targeted at engaging suicidal patients in treatment, in an African setting.

Objective: This study assessed the effect of an ED-based intervention on treatment engagement (compliance with out-patient appointment) among patients with history of

suicidal attempt, 3 months after discharge from the ED to an out-patient clinic in Nigeria.

Method: The study was conducted at the ED of the Federal Neuro-Psychiatric Hospital Yaba, the only 24-hour facility based Psychiatric emergency services in Lagos, Nigeria. Following comprehensive psychiatric evaluation patients with history of suicidal attempts (n=32 in each group) were randomly assigned to a 'treatment as usual' group (Group A) and an intervention group (Group B) before discharge from the ED to the out-patient clinic. Continuity of compliance with out-patient clinic appointments was followed up for 3 months from the point of discharge from the ED. Intervention for patients in Group B included problem solving/supportive counseling, access to 24-hour phone contact of a Psychiatrist and systematic telephone contact by a key worker.

Results: There were no significant differences in the socio-demographic and clinical characteristics of patients in both groups at baseline. At 3 months post-discharge from the ED, the patients in the intervention group were more likely to be engaged in services, as compared with Group A where the majority had dropped out of treatment (OR=3.71, p<0.001, 95% C.I= 2.53-7.12). Patients in Group B were also less likely to have suicidal intent at 3 months follow up (p<0.001).

Conclusion: Interventions initiated in the emergency department can successfully engage suicidal patients in treatment, in the short term. Further studies on a larger sample are needed to confirm and extend these findings in the long-term. ED treatment for suicidal patients should be scaled up from routine triage care to include interventions targeted at facilitating treatment engagement.

P6-02
COMMUNICATION BARRIERS TO BUPRENORPHINE AND METHADONE PROVISION AFTER HURRICANE SANDY: LESSONS FROM TWO OPIOID MAINTENANCE SYSTEMS IN NEW YORK CITY

Lead Author: Christina Ahn, M.D.

Co-Author(s): Bridget McClure, Lauren Moy, Vishal Gupta, Elspeth Kelly, John Rotrosen, and Helena Hansen

ABSTRACT:
Objective: In the public sector, office-based buprenorphine therapy is a significant departure from traditional methadone clinics. Hurricane Sandy flooded large sections of New York City, closing methadone and buprenorphine clinics; in the case of four major public hospitals, these closures lasted for over four months. This study compared how these two opioid maintenance systems addressed service disruptions in New York City during and after Hurricane Sandy.

Methods: Outpatient prescribers and their supervising substance abuse service administrators were identified using lists from New York City municipal and Veteran's Administration hospitals, the SAMHSA buprenorphine referral service, and the New York State Medicaid office. Index participants identified additional participants. Eight to twenty four weeks after Hurricane Sandy, prescribers and administrators were invited to participate in face to face semi-structured interviews about the barriers encountered, and strategies employed, to continue care for opioid maintained patients during Hurricane-related closures and relocation of public clinics. Specific topics included barriers to communication with patients and with colleagues, regulatory or patient privacy restrictions that interfered with such communication, facilities and provider cross-coverage issues, patient responses to crisis management strategies, and medication supply problems. Interview transcripts were analyzed using iterative thematic coding techniques with multiple coders and checks of inter-coder reliability.

Results: Fifty-one providers and administrators were interviewed from 13 different hospitals. Methadone prescribers described regulatory barriers to guest dosing and communication barriers with other clinics preventing dose verification, leading to redirection of patients from clinics to emergency rooms, subsequent undertreatment of displaced patients, and in some cases, overtreatment with the risk of overdose. Buprenorphine prescribers described communication barriers with patients and pharmacists. They also reported thin or nonexistent professional networks with other buprenorphine prescribers, leaving them with no back-up prescribers, leading some prescribers to lose contact with their patients.

Conclusions: As entire institutions closed and were displaced, communication was identified as a key barrier that hindered continuity of care in the public sector opioid maintenance treatment system. These findings point to the need for a centralized methadone registry, as well as interventions to strengthen professional networks of buprenorphine prescribers, allowing independent office-based prescribers to provide continuous care during service disruptions. This study provides invaluable information about communications and back-up systems for improving future health services, disaster contingency planning and everyday care in opioid maintenance treatment.

P6-03
ELEVATED BLOOD UREA NITROGEN AND HOSPITAL OUTCOME OF PSYCHIATRIC PATIENTS

Lead Author: Zainab Al-Dhaher, M.D., M.Sc.

Co-Author(s): Sameer Khan MBBS, Christoph U Correll M.D., Peter Manu M.D.

ABSTRACT:
Financial Disclosures: Dr. Correll has been a consultant and/or advisor to or has received honoraria from: Actelion, AstraZeneca, Bristol-Myers Squibb, Cephalon, Eli Lilly, GSK, IntraCellular Therapies; Ortho-McNeill/Janssen/J&J, Merck, Novartis, Otsuka, Pfizer, and Sepracor/Sunovion. Drs. Manu, Al-Dhaher and Khan have nothing to disclose.

Background: Elevated blood urea nitrogen (BUN) is associated with increased severity of illness and mortality in patients hospitalized for medical conditions, but its clinical outcome has not been studied in psychiatric inpatient populations.

Objective: To determine the clinical outcome of psychiatric inpatients with elevated BUN on admission.

Method: Retrospective cohort study of 1,000 adults consecutively admitted to a free-standing psychiatric hospital in 2010. Emergency transfer to a general hospital was used as a proxy marker for poor medical outcome in 939 patients with usable data.

Results: Fifty-two patients had admission azotemia (BUN > 24 mg/dL). Medical deteriorations requiring emergency transfer to a general hospital occurred in 46.2% (95% confidence interval 32.6-49.8) of azotemic patients and 12.6% (95% confidence interval 10.4-14.8) of those with normal BUN levels (p<0.0001). Older age, dementia, arterial hypertension, diabetes mellitus, diuretic use and BUN/creatinine ratio > 20 suggestive of pre-renal azotemia were significantly more frequent in patients with elevated BUN on admission (p<0.0001). Increasing BUN was the reason for transfer in only 2 of the 24 azotemic patients with serious medical deteriorations.

Conclusions: Admission azotemia is relatively common among psychiatric inpatients and is associated with a high rate of significant medical deteriorations. The presence of azotemia should trigger prompt medical evaluation and enhanced monitoring to prevent, identify and treat somatic disorders.

P6-04
COCAINE-INDUCED CATATONIA POTENTIATED BY CANNABIS INTOXICATION

Lead Author: Melissa Begolli, M.D.

Co-Author(s): Fernando Silvestre, M.D.; Raj Addepalli, M.D.; Cintia Rengel, M.D.; Jamar Williams, MPH, M.D.

ABSTRACT:
Introduction: Many hypotheses have been proposed about the pathophysiology of catatonia. Here we propose an association between catatonia and cocaine potentiated by cannabis use.

Case Description: Mr. S is a 29 year old man with psychotic disorder and substance abuse who was brought into the Emergency Department by NYPD for engaging in "bizarre behavior" in a city park. The patient was standing in the park for four hours and staring into space. Upon interview in the ED, Mr. S stared blankly. He did not talk or answer questions, but did follow simple commands such as sit and stand. His signs included catatonic behavior such as posturing, stupor, forced grasping, and inappropriate laugh. Specifically, he exhibited robotic and rigid military style march, fully extending his legs prior to moving his torso and making precise turns. In the ED, he received lorazepam 2mg IM without immediate remission of his catatonic state. The physical exam was generally unremarkable except for tachycardia and mildly elevated blood pressure. Initial laboratory work revealed a urine drug screen positive for cannabis and cocaine; all other laboratory test results were within normal parameters. EKG demonstrated sinus arrhythmia. Mr. S was started on risperidone 1 mg bid and lorazepam 2mg for sedation. During the first 24 hours of admission he continued to be catatonic and anorexic. He was maintained on risperidone 2mg bid and diphenhydramine 50mg at bedtime. Gradually his catatonic attitude and behavior improved. On the seventh day of admission he began to speak. He recounted using cocaine two days prior, and cannabis one week before being admitted; and reported a long history of preferred cannabis use starting at age 18; along with occasional use of cocaine and ecstasy.

Discussion: In our review of the literature on cocaine-induced catatonia, we found one purported case of cocaine-induced catatonia. The evidence to support this link is limited and the biochemical phways involved are yet to be elucidated. Notwithstanding, one other study has concluded that cannabis, the principal psychoactive constituent of cannabis, increases levels of cocaine in brain and blood plasma and subjectiipal psychoactive constituent of cannabis, increases levels of cocaine in brain and blood plasma and subjective euphoria(6,7,8). As in this patient, our experience is that many individuals use marijuana and cocaine concomitantly for enhanced effect. We posit that if in fact cocaine does play a role in inducing catatonia, it is plausible that its increased bioavailability in plasma and the brain secondary to the effects of cannabis would therefore favor its potentiated action on neurons that are involved in triggering catatonia.

Conclusion: we opine that additional investigation is needed to elucidate the role of cocaine in the neural pathways of the human brain, and the biochemical pathways of cocaine-induce catatonia.

P6-05
THE POSSIBILITY OF FALSE- POSITIVE URINE SAMPLES FROM THE WIDESPREAD USE OF AN NSAID: A

CASE REPORT

Lead Author: Haroon Burhanullah, M.D.

Co-Author(s): Valiveti, S, M.D. Berman, J, M., M.D., Sheikh, Sarah, M.D., Haroon Burhanullah , M.D..

ABSTRACT:
Introduction: This report highlights the possibility of a correlation between the use of NSAIDs and a false – positive urine drug screening for barbiturates and cannabis. False- positive urine drug screening for substances of abuse is infrequent, but does occur in a number of routinely prescribed and nonprescription medications. Some of these medications include anIntroduction

This report highlights the possibility of a correlation between the use of NSAIDs and a false – positive urine drug screening for barbiturates and cannabis. False- positive urine drug screening for substances of abuse is infrequent, but does occur in a number of routinely prescribed and nonprescription medications. Some of these medications include antihistamines, antidepressants, antibiotics, ibuprofen, naproxen, Vicks inhaler, and other agents.

Objective : To establish the possibility of false - positive urine drug screening from common medications.

Case: A 48 year -old African American male presented to the Mentally Ill Chemically Addicted (MICA) partial hospitalization day program for a three month period of time, with a history of Heroin Dependence with Physiological Dependence, alprazolam Dependence with Physiological Dependence, Alcohol Dependence with Physiological Dependence in Sustained Full Remission, Cannabis Abuse, Prior history of Phencyclidine, and Post Traumatic Stress Disorder, chronic. The last usage of alprazolam, cannabis, and heroin through the para nasal route was 3 weeks prior to the day of the intake.

The patient's urine samples were taken on a weekly basis from the beginning of his admission into the day program. The treatment team at the day program considered the patient a reliable historian, so the inconsistencies in the urine samples were a perplexity. In the beginning, the sample was positive for barbiturates, cannabis, and benzodiazepines. Since the patient had a history of abusing cannabis and benzodiazepines, it was consistent with what was expected. However, the barbiturate usage was unreported and a confusion for the staff and patient. Additional urine samples revealed negative results for benzodiazepine and opioids, but positive results for cannabis and barbiturates.

Discussion: This patient in the case described had been using ibuprofen on a daily basis, while participating in the MICA partial hospitalization day program. To discern whether the patient was still actively using the substances, weekly urine samples were collected. The positive urine samples for cannabis and barbiturates were possible in the following situations: the patient had relapsed on illicit substances or it was a false- positive result. Due to the patient's trustworthiness, the treatment team had chosen to look into the possibility of a false- positive result.

Conclusion: This case of false- positive urine sampling from the concurrent use of NSAIDs illustrates the importance of a careful patient history and confirmatory testing.

P6-06
IMPROVING LEVEL OF FUNCTIONING AND QUALITY OF LIFE IN MENTAL HEALTH PATIENTS VIA SMARTPHONE APPS

Lead Author: Ying A. Cao, M.D.

ABSTRACT:
Objective: Investigate ways in which software applications (apps) can make smartphones a new kind of timely, organized, multipurpose, personalized, and effective toolbox for minimizing symptom- and disease-burdens and maximizing the overall level of functioning and quality of life in mental health patients.

Method: While most studies focused on apps that are more disease-based and psychoeducation-oriented from clinicians' perspective, this study focused on management of symptoms and holistic mental health and wellness from patients' perspective by: 1) identifying specific complaints commonly encountered in psychopharmacological as well as psychotherapeutic settings; 2) surveying Apple's AppStore and compiling shortlists of the most relevant apps based on ratings and reviews by the general public as well as the author; and 3) demonstrating how to utilize these apps by showing actual screenshots of these apps in action.

Results: Shortlists and screenshots of the most effective smartphone apps were compiled for each of the common patient complaints that are categorized into four areas of mental healthcare: 1) symptom management--anxiety, impulse control, mood dysregulation, distractibility and forgetfulness, insomnia, loneliness, etc; 2) side-effect management and preventative care--metabolic syndrome, weight gain, etc; 3) record keeping--summary of therapy sessions, mood diary, sleep log, thoughts records, coping cards, alarms and reminders, personalized psychoeducation collection, etc; and 4) complementary and integrative mental healthcare--music therapy, mindfulness meditation, biofeedback, medical hypnosis, memory and concentration games, yoga, peer-support forums, etc.

Conclusion: Extensive reviews and trials of the existing apps suggest smartphones--through their 24-7 accessibility and versatility--can serve as timely and effective re-enforcers that can help habituate adaptive thoughts and behaviors and thus attain higher level of functioning and quality of life. Some obvious limitations include affordability and the requirement of a certain level of baseline functioning to operate smartphones. However, as smartphones become ever more affordable and easy-to-use, some future work would include 1) conducting clinical trials of smartphone apps in the appropriate patient populations to assess efficacy, 2) relaying feedback from patients and clinicians to apps developers to optimize efficacy, and 3) training clinicians to facilitate patients' utilization of the appropriate apps.

P6-07
DOES SERIOUS MENTAL ILLNESS INFLUENCE TREATMENT DECISIONS OF PHYSICIANS AND NURSES?

Lead Author: Scott Cardin, M.D.

Co-Author(s): Greer Sullivan, M.D.; Christina Reaves, MPH; Xiaotong Han, MS; Snigdha Mukherjee, PhD; Scott Morris, PhD; Patrick Corrigan, PsyD

ABSTRACT:
Introduction: Although at high risk for chronic medical conditions, persons with serious and persistent mental disorders, such as schizophrenia, receive poor care for their physical health problems. Relative to those without mental illness, persons with serious mental disorders receive sub-optimal medical, preventive, and specialty health care. While the reasons for this pattern are multi-factorial and complex, one potential contributor that has received very little attention is providers' stigmatizing attitudes about mental illness.

Bias on the part of health care providers has been documented in several areas, including bias related to gender, race, and socioeconomic status. The goal of this project was to assess the influence of serious mental illness on providers' decision-making about treatment; and to compare the effect of mental illness on the decision-making of four different provider types (primary care physicians, primary care nurses, psychiatrists, and mental health nurses).

Methods: To investigate provider bias among providers as a result of serious mental illness, we conducted a vignette survey study. The study was informed by a conceptual model based on extensive literature review. The model proposes that providers' practice behaviors (or, more precisely, behavioral intentions) and expectations represent a function of provider characteristics (including provider personality traits [specifically authoritarianism, empathy , and self-awareness], training and specialty) and stigmatizing beliefs and attitudes. The model holds that stigmatizing attitudes and beliefs are associated with hypothetical provider behaviors (defined as "outcomes" in this project), such as intention to refer patients for psychosocial rehabilitation or to weight reduction programs

Results: Results reveal that all provider groups (primary care and mental health doctors and nurses) viewed persons with SMI more negatively than they viewed persons without SMI on most attitudinal and behavioral outcome variables, including those related to treatment decisions. This finding suggests that stigma-reduction interventions that target all provider groups are needed.

P6-08
LAMOTRIGENE CAUSING DRESS SYNDROME: A CASE REPORT AND REVIEW OF TREATMENT FOR ADOLESCENT BIPOLAR DISORDER

Lead Author: Ali Abbas Asghar-Ali, M.D.

Co-Author(s): Almari Ginory, DO; Mathew Nguyen, M.D.

ABSTRACT:
Drug reaction with eosinophilia and systemic symptoms (DRESS) is a hypersensitivity syndrome most commonly associated with antiepileptics, allopurinol, and sulfonamides. It is a severe adverse reaction associated with fever, rash, eosinophilia, lymphadenopathy, and internal organ involvement. Herein, we present a case of a 17 year-old Caucasian female with Bipolar Disorder type II and Posttraumatic Stress Disorder treated with Lamotrigine who was admitted to our hospital for treatment of DRESS syndrome. Her symptoms were atypical in that she developed a rash with flu-like symptoms that resolved after discontinuation of Lamotrigine and returned 8 days later. In patients presenting with rash and systemic symptoms, DRESS syndrome should be considered and treated appropriately to reduce mortality, which can be as high as 10%. Treatment includes withdrawal of the offending agent and corticosteroids. Our presentation aims to make physicians more aware of this rare adverse drug reaction. We will also analyze the FDA approved treatments for Bipolar Disorder in adolescents. If these guidelines were followed, Lamotrigine would not have been prescribed and medical complications for the patient could have been prevented.

The patient was a 17-year-old 135lb Caucasian female initially admitted to an inpatient psychiatric hospital due to anger outbursts and violent threats towards her family members. During this hospitalization, she was diagnosed with Bipolar II Disorder and Posttraumatic Stress Disorder (PTSD). She was previously tried on fluoxetine, sertraline, citalopram, venlafaxine, and lithium without any noticeable benefit. Patient was started on Lamotrigine 25 mg PO BID monotherapy and discharged on the same dose.

Three weeks after starting Lamotrigine, the patient began

to develop a rash as well as general flu-like symptoms. Her mother was concerned this was an adverse drug reaction, and Lamotrigine was discontinued. The rash resolved within 3 days. Approximately 8 days later, the patient developed a new onset diffuse rash, fever with a maximum temperature of 103ºF, abdominal upset, and generalized fatigue. Upon admission, she had elevated liver function tests (AST 2057, ALT 2076, Alk Phos 455, Total bilirubin 6.5, Direct bilirubin 6.1, and Albumin 3.2). Ammonia was 157. Toxicology and infectious screens came back negative. Her absolute eosinophil count elevated at 0.85x109L-1. She was diagnosed with having DRESS syndrome based on the above symptoms and a history of treatment with Lamotrigine.

Treatment for her symptoms included Methylprednisolone 125 mg IV daily. She responded to this treatment and her liver enzymes trended down, but she subsequently developed steroid induced hyperglycemia that required treatment with insulin. She was advised to follow-up with her outpatient psychiatrist once her liver enzymes normalized with the recommendation to start an FDA approved treatment for Bipolar Disorder in adolescents, an atypical antipsychotic.

P6-09
FOREIGN BODY INGESTION AND THE GAG REFLEX

Lead Author: Kevin Chou, M.D.

Co-Author(s): Rudresh Bhatt, D.D.S.; Jeffry R. Nurenberg, M.D.; Elizabeth C. Dimitrios, M.S.W.; Steven J. Schleifer, M.D.

ABSTRACT:
Objective: Foreign body ingestion (fbi) is an uncommon but serious and life threatening problem in long term psychiatric patients with psychoses and impulsive disorders. It often consumes substantial clinical resources. Factors contributing to fbi have not been extensively studied. This study was undertaken to explore whether fbi patients have an altered gag reflex, with the diminished gag reflex facilitating the swallowing of inedible or large objects.

Materials and Methods: As part of an ongoing performance improvement project to assess factors contributing to fbi, a quantitative assessment of the gag reflex was instituted in the routine patient dental examinations at Greystone Park Psychiatric Hospital (GPPH). Patients with a history of foreign body ingestion in hospital were identified from clinical records. For the standardized measure, dental cotton swabs were inserted into the oral cavity, measuring the distance from the upper central incisors and carefully proceeding along the hard palate until a gross pharyngeal gag reflex was elicited.

Results: Gag reflex measurements have been obtained for 93 patients, 8 with in-hospital fbi. The mean gag reflex distance for fbi patients was significantly greater than that of the non-fbi patients (SPSS, t-test, equal variances not assumed): fbi 89.5+10.2(sd) mm; non-fbi 80.1+4.2 mm (t=2.6; p<0.04).

Conclusion: The evidence for a diminished gag reflex in fbi patients with psychiatric disorders suggests that the gag reflex may be a factor in initiating or sustaining fbi behavior. The presence or development of a diminished gag reflex may influence impulsive behavior "choices", such as permitting fbi versus other (e.g., cutting) behaviors. The contribution of the gag reflex to fbi in different patient subgroups and of other factors affecting the gag reflex warrant further consideration.

P6-10
CURRENT TREND? USE OF THE CONDUCTED ELECTRICAL DEVICE IN A PSYCHIATRIC HOSPITAL

Lead Author: Alexander de Nesnera, M.D.

Co-Author(s): David G. Folks, M.D.; Robert J. MacLeod, DHA

ABSTRACT:
Objective: New Hampshire Hospital (NHH) is a 152-bed subspecialty hospital treating individuals involuntarily hospitalized due to being a danger to themselves or others as a result of mental illness. The hospital has experienced a trend toward increasing episodes of violence on our inpatient units. We describe the successful implementation of a policy allowing the use of a conducted electrical device (CED) on inpatient care units. To our knowledge, this is the first description of such a policy implementation.

Method: New Hampshire Hospital administration surveyed the National Association of State Mental Health Program Directors, the American Medical Association and Joint Commission standard of care and practice guidelines. None had guidelines that existed for use of a CED in an inpatient psychiatric setting. NHH medical and nursing staff, hospital administration, and campus police worked together to develop a policy that achieved a balance between patient care and safety.

Results: The policy was implemented in August 2011. In the fourteen months since the implementation of this policy, the CED has been used three times. There is no evidence of an increasing pattern of use of the CED since implementation of the policy.

Conclusions: New Hampshire Hospital successfully implemented a hospital policy allowing for the use of a CED on patient care units. To our knowledge, this is the first description of a process allowing the implementation of CED use in a psychiatric facility. Other health care facilities treating violent patients may, with proper planning and training, successfully develop policies allowing for the safe use of the CED.

P6-11
TRANSITION FROM AN ADMITTING CENTER TO AN EVALUATION AND PSYCHIATRY EMERGENCY SERVICES (PES): ONE TEAM OF ADMITTING, EVALUATING AND ON CALL MDs

Lead Author: Maria De Pena-Nowak, M.D.

ABSTRACT:
Since July 2013, New York Presbyterian Hospital-Westchester Division, a free standing psychiatric hospital part of the New York Presbyterian Behavioral Network, adopted a new model of care which uniquely integrates, as one team, the psychiatrists completing admissions with those previously scheduled to be on call on weekends and after hours. Consequently, the newly created Evaluation and Emergency Psychiatry Service has a team of doctors working flexible 12h shifts that evaluate and decide the most appropriate level of care as well as deliver acute crisis management for those patients already admitted to one of the 250 inpatient beds units. As a team, this group of physicians works in close collaboration with the unit based psychiatrists as well as the departments of medicine, social work, nursing and ancillary, supportive staff. Furthermore, they reach out to referring Emergency departments and other providers for M.D. to M.D. sign out in addition to the more traditional hand off with the inpatient units' colleagues. The advantages of the new compared to the old model are several: ability to start treatment on day 1 of admission and not just admit patients to inpatient units, develop a therapeutic alliance with patients early in their treatment with increased number of successful outcomes at time of crisis during patients' length of stay and the opportunity to deliver a 360 degree comprehensive treatment plan for all patients as the admitting/crisis management team pairs with the clinicians entrusted with the task to design inpatient treatment plans.

P6-12
QUALITATIVE BARRIERS OF EXPANDING ACCESS TO BUPRENORPHINE

Lead Author: Jeffrey R. DeFlavio

Co-Author(s): Stephanie A. Rolin, MPH, M.D. Candidate; Benjamin R. Nordstrom, M.D./PhD; Louis A. Kazal, M.D.

ABSTRACT:
Purpose: The licit sale of opioid pain relievers quadrupled between 1999 and 2011, and the number of Americans illicitly using these drugs more than doubled. Opioid pain relievers are the second most commonly abused class of drugs behind cannabis, and account for 75% of the prescription drugs misuse. Primary care physicians, in concert with psychiatrists, can play a central role in addiction treatment - yet there is a gap between the available effective therapies for addiction and their implementation in clinical practice. Effective treatments for opioid dependence exist, including buprenorphine maintenance therapy (BMT) which has been shown to be reduce opioid use and overdose death in opioid-dependent populations. Yet buprenorphine remains an example of an evidenced-based, but underutilized, treatment in primary care. This paper will present a qualitative review of barriers to implementation of buprenorphine maintenance treatment (BMT) among primary care physicians.

Methods: Cross-sectional survey of family physicians with no first-hand experience providing buprenorphine. Physicians were recruited for this survey through the he New Hampshire and Vermont state chapters of the American Academy of Family Physicians (AAFP). Qualitative questions focused on personal opinion of opiate addiction/treatments and factors influencing buprenorphine adoption. Survey results were analyzed used inductive analysis technique and software program ATLAS.ti 7.0.

Results: Ninety-seven family physicians with no personal experience with buprenorphine completed the survey. Among barriers to providing buprenorphine for addiction treatment, common themes addressed in open-ended questions included (1) lack of time; (2) insufficient knowledge; (3) no interest; (4) mistrust of people with addiction; (5) doubt of the efficacy of buprenorphine; and (6) difficult patient population. Time was the most frequently identified barrier, identified by twenty-five of the respondents. Providers suggested this referred both to a feeling that their practices were already overburdened ("Practice is already full with waiting list for primary care") and a lack of time in daily schedule ("It takes a lot").

Discussion: This study aims to identify perceived barriers to buprenorphine treatment. The main findings indicate that physicians feel either unable to provide BMT (lack of time or knowledge), or unwilling to provide BMT (lack of interest or mistrust). The results suggest significant barriers remain, including stigma against patients with addiction and opioid maintenance therapy. Addressing these barriers may lower resistance to buprenorphine adoption, and understanding these barriers helps provide insight into possible expansion of the community of physicians offering evidence-based addiction treatment.

P6-13
ASSOCIATION OF NEUROKININ-1 RECEPTOR GENE WITH NOVELTY SEEKING IN ALCOHOLICS

Lead Author: Saria El Haddad, M.D.

Co-Author(s): Chamindi Seneviratne; Nassima Ait-Daoud

ABSTRACT:
Alcoholism is influenced by temperament, particularly novelty seeking (NS). High NS is strongly associated with alcohol dependence (AD) amount of drinking and severity of dependence. Individuals who are novelty-seeking are likely to use avoidant coping strategies, and unlikely to use active-cognitive and active-behavioral strategies and tend to have higher stress levels. They constitute a subgroup of alcoholics who are often difficult to treat. Pharmacologic studies employing animal models and human imaging techniques have implicated neurokinin system as one of the neural circuitry underlying pathophysiology of higher stress levels seen among alcoholics. More specifically, the blockade of the neurokinin-1 receptor, NK1R – the preferred receptor for substance P – was shown to blunt the emotional stress induced by alcohol-related cues in humans. Previously we reported that allelic variations in the NK1R gene are associated with greater risk for AD. The aim of the present study was to examine whether NK1R genetic variations might have effects on NS behavior in alcoholics.

Two hundred seventy six unrelated Caucasian treatment-seeking alcoholics were included in the analysis. AD was diagnosed using the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, 4th edition.

Each participant completed the most commonly used version of the temperament and character inventory devised by Cloninger, which assesses personality traits by means of 240 items with forced binary answers. NS scores were calculated for each participant using the binary answers.

Associations of all 11 NK1R SNPs with NS were assessed at both the individual SNP and haplotype levels, controlling for age and gender of the participants.

Our findings suggest that NK1R genetic variants are significantly associated with novelty seeking behavior in alcoholics of European descent. These findings may have pharmacogenetic relevance for NK1R agents for the treatment of anxiety, alone or co-morbid with alcoholism. Replication of these results is greatly needed in larger samples of both European and other populations.

P6-14
THE EFFECT OF PHYSICIANS' BODY WEIGHT ON PATIENT ATTITUDES: IMPLICATIONS FOR PHYSICIAN SELECTION, PHYSICIAN TRUST, AND MEDICAL ADVICE FOLLOWING

Lead Author: Jessica A. Gold, M.S.

Co-Author(s): Rebecca M. Puhl, PhD, Joerg Luedicke, M.S., Jenny A. DePierre, B.A.

ABSTRACT:
Introduction/Hypothesis: Research has documented negative stigma by health providers toward overweight and obese patients, but it is unknown whether physicians themselves are vulnerable to weight bias from patients. This study assessed public perceptions of normal weight, overweight, or obese physicians to identify how physicians' body weight affects patients' selection, trust, and advice following of providers.

Methods: A sample of 358 adults completed an online experimental survey to assess their perceptions and opinions of physicians described as either normal weight, overweight or obese.

Results: Respondents reported more mistrust of physicians who are overweight or obese, were less inclined to follow their medical advice, and were more likely to change providers if their physician appeared overweight or obese, compared to normal weight physicians who elicited more favorable opinions from respondents. These biases remained present regardless of participants' own body weight, and were more pronounced among individuals who demonstrated stronger weight bias toward obese persons in general.

Conclusions/***Discussion:*** Physicians perceived to be overweight or obese may be vulnerable to biased attitudes from patients, including negative perceptions about the doctor-patient relationship such as physician selection, physician trust, and advice following. Stigma reduction approaches may be beneficial to educate patients (and the general public) about weight bias, to help challenge stereotypes that could ultimately threaten the quality of provider-patient interactions and the extent to which patients follow advice and feel comfortable discussing their health concerns.

P6-15
CRIMINAL RECORDS AVAILABLE ONLINE: RELIABILITY, PRACTICAL APPLICATIONS, AND ETHICAL ISSUES

Lead Author: Matthew Wainwright Grover, M.D.

Co-Author(s): Merrill Rotter, M.D.

ABSTRACT:
The advent of improved technology and communication has caused an exponential increase in the amount of publicly available information that can be utilized by forensic psychiatrists. The Department of Corrections in many states provides an online offender database, which can be used as a resource to obtain collateral information. The development of such databases occurred as the result of victim's rights legislation, which led to the creation of VINELink (Victim Information and Notification Everyday), and funding from programs like the National Criminal History Improvement Program.

This poster will offer an overview of the available data on a state level regarding criminal histories, incarcerations, and convictions. It will explore the utility of such information, the reliability of the information presented, and the ethical issues that may arise from obtaining such information.

P6-16
THE MERGING OF PUBLIC SUBSTANCE ABUSE PROGRAMS IN THE WAKE OF HURRICANE SANDY: A NARRATIVE AND LESSONS LEARNED

Lead Author: Vishal Gupta, B.S.

Co-Author(s): Helena Hansen, M.D., PhD, Laura Duncan, BA, Lauren Moy, MA, Ronnie Swift, M.D.

ABSTRACT:
Background: Hurricane Sandy flooded large sections of New York City, leaving Bellevue Hospital, the largest public hospital in the city, closed for three months. This led to the translocation of Bellevue Hospital patients and staff to Metropolitan Hospital, and required them to share limited resources with Metropolitan staff and patients in order to continue to provide care.

Methods: Face to face semi-structured interviews were conducted with 35 staff members consisting of physicians, nurses, social workers, and counselors from substance abuse programs at Bellevue and Metropolitan Hospitals. The interviews took place two to seven months after Hurricane Sandy. Interview transcripts were analyzed using iterative thematic coding techniques with multiple coders and checks of inter-coder reliability.

Findings: The issues that arose included differences in institutional practices, such as the use of methadone tablets versus liquid at Metropolitan, and the lack of a central methadone dose registry, as well as issues of sharing scarce resources. There was one window to dispense methadone, difficulty with dose verification and communication due to downed phone lines, and the grouping of nurses and counselors into a single office. All of these issues resulted in extraordinarily long lines and the need for crowd control. Among the more successful interventions were the opening of a second window, the decision by administrators to keep Bellevue patients with their original providers, and allocating space within Metropolitan Hospital in order to keep Bellevue staff in proximity to each other. Additionally, there are many mechanisms that were tested and have proven fruitful in abating the issues involved with a large crowd, such as alternating clinic days with an increased number of take home methadone doses, counselor interventions to de-escalate tensions while patients waited, and a numbering system to promote fairness in line.

Discussion: These findings have important implications for disaster response. They point to the need for a centralized methadone registry and better communication about differences in institutional rules. Institutional adaptations, such as keeping original teams of patients and staff intact, and arranging group meetings with patients to discuss updates and issues about procedures, may be necessary. The Metropolitan-Bellevue merger created a novel experiment and offers insights about disaster management to clinic administrators.

P6-17
PREDICTIVE UTILITY OF SUICIDE ASSESSMENT INSTRUMENTS ON URGENT READMISSION OUTCOMES IN A SAMPLE OF ADULT PSYCHIATRIC INPATIENTS

Lead Author: Ahmad Hameed, M.D.

Co-Author(s): Michael A Mitchell, Eric A Youngstrom PhD, Roger E Meyer M.D, Alan J Gelenberg M.D.

ABSTRACT:
Background: Changing healthcare environment directs attention towards hospital re-admissions. Psychiatric patients have a higher re-admission rate. The prevalence of suicide-related psychiatric admissions makes it urgent to determine what, if any, predictive utility is available in suicide assessments on hospital re-admissions. There is increasing interest in C-SSRS with regard to both clinical and research applications, i.e. screening. Further research is needed to demonstrate the predictive utility, if any, that CSSRS has on psychiatric hospital re-admissions.

Method: Data was collected part of an original study comparing suicide assessment instruments with adult, psychiatric in-patients (N =199). The Risk Assessment Measure (RAM) collected information on evidence-based SUICIDE risk and protective factors. C-SSRS was administered in an interview format. Re-admission data was collected and evaluated.

Results: 11 cases were re-admitted within 30 days and 20 cases were re-admitted within 90 days. Bivariate analyses indicated that readmission was significantly more likely to occur among men, those with a self-reported lack of reasons to live (RAM factor 1), and those with more psychotic features (RAM factor 2). The combination of lifetime suicidal behavior and ideation intensity from the current episode on the CSSRS predicted subsequent readmission, p=.020 (p=.084 for 30 day readmission); but neither ideation nor

behavior made a significant contribution to predicting readmission at either 30 or 90 days; nor did past month ideation or behavior before index admission. After controlling for CSSRS ideation and behavior, the RAM scores no longer were significant.

Conclusion: Results were largely consistent with prior findings, inasmuch as CSSRS rated attempts and severity of ideation predicted risk of urgent readmission within 90 days, with the trend also appearing similar for urgent readmission within 30 days. Results also confirmed prior findings that men are at higher risk of readmission, as well as those with psychotic features and fewer reasons to live (RAM). Several other variables identified in prior work did not significantly relate to urgent readmission, including divorce and other RAM risk factors, but this is qualified by the low rate of readmission overall.

Altogether, CSSRS and RAM showed small to medium sized associations with recidivism, sometimes achieving conventional statistical significance and sometimes just missing. Regression models examining combinations of scales found overlap in their prediction of recidivism, with none providing clear incremental value or robust superiority to other scales. More complicated models did not improve prediction, generally shifting to nonsignficance as the increased complexity reduced power rather than improving fit.

P6-18
SUICIDAL IDEATION AND BEHAVIOR IN ADOLESCENTS AGED 12-16 YEARS: A 17-YEAR FOLLOW-UP

Lead Author: Benjamin Joffe

Co-Author(s): Ryan J Van Lieshout M.D. PhD FRCP(C) Laura Duncan MA; Michael H Boyle PhD

ABSTRACT:
Introduction: Suicidal ideation and behavior are common problems among adolescents. Although completed suicide is one of the commonest causes of death in this age group, there is evidence that the ratio of suicidal ideation/behavior to completed suicide is very high. The high prevalence of suicidal behavior and the relatively low frequency of completed suicide does not exclude the possibility that suicidal ideation/behavior in adolescents may be associated with psychiatric and physical health problems in adulthood. A related concern is parental unawareness of adolescent suicidal behavior noted in small clinical samples. Evidence in general population samples on agreement between parent-teacher and adolescent assessments of youth suicidal ideation/behavior is sparse, although there are well known, large discrepancies between youth, their parents, and their teachers in the reporting of symptoms, particularly in the assessment of emotional problems.

Objectives: The objectives of this study were to: (1) estimate the prevalence and agreement on youth suicidal ideation/behavior as reported by adolescents in the general population aged 12-16 years, their parents, and their teachers; (2) examine family and youth characteristics associated with adolescent reports of suicidal ideation/behavior; and (3) quantify the strength of association between adolescent reports of suicidal ideation/behavior at baseline with their health and functioning assessed 17 years later, adjusting for their family socioeconomic circumstances at baseline and co-existing mental health problems.

Method: The data for this research come from the Ontario Child Health Study (OCHS), a prospective general population study of child health, psychiatric disorder, and adolescent substance use. The OCHS began in 1983, with follow-ups in 1987 and 2001. In this study, the prevalence of suicidal ideation/behavior in 1983 and its association with future mental health in 2000 was evaluated in 1248 adolescents aged 12 to 16 years.

Results: Approximately 13.3% (95%CI=11.5-15.3) of adolescents self-reported suicidal ideation/behavior. Adolescent agreement with parent (?=0.07) and teacher (?=0.05) reports was low because adults identified so few subjects with suicidal ideation/behavior. At follow up in 2000, when subjects reached adulthood, the predictive value of adolescent self-reports of suicidal behavior/ideation was accounted for by respondent sex and adolescent emotional problems.

Conclusions: Adolescents, aged 12 to 16 years, in the community, have a high prevalence of suicidal behavior/ideation which is not recognized by significant adults in their life. Furthermore, adolescents with suicidal ideation or behavior may be at risk for persistent psychiatric and emotional dysfunction in adulthood.

P6-19
ASSOCIATION BETWEEN TYROSINE AND SMOKING IN PATIENTS WITH SCHIZOPHRENIA

Lead Author: Jyoti Kanwar, M.D.

Co-Author(s): Olaoluwa Okusaga; Dietmar Fuchs; Olesja Muravitskaja; Ayesha Ashraf; Sarah Hineman; Ina Giegling; Annette M. Hartmann; Bettina Konte; Marion Friedl; Dan Rujescu; Teodor T. Postolache

ABSTRACT:
Background: Patients with schizophrenia are known to have higher rates of smoking. Smoking has been implicated in various inflammatory processes. Inflammation decreases tetrahydrobiopterin levels that are in turn essential for functioning of tyrosine hydroxylase enzyme that aids conversion of phenylalanine to the essential amino acid tyrosine, precursor of dopamine. Thus, we tested the hypothesis that patients with schizophrenia who smoke will have decreased tyrosine and elevated phenylalanine levels. ***Method:*** Tyrosine, phenylalanine, tryptophan and kynurenine levels were measured in 950 patients (Male 600, Female 350, Age range 38± 11.6) with diagnosis of schizophrenia confirmed by SCID. Patients were recruited in both inpatient and outpatient setting in Munich, Germany. History of smoking was obtained by detailed clinical interviews and Fagerstrom nicotine dependence test. Data on PANNS scores, BMI and antipsychotic doses (in chlorpromazine equivalents) were also obtained. Statistical methods included paired t test and logistic regression multivariate models with adjustment for demographics and medication use.

Results: 'Smoker' status was significantly associated with decreased tyrosine levels (p = 0.012. Differences in phenylalanine, phenylalanine/ tyrosine ratio, tryptophan, kynurenine and their ratio were not significant. Tyrosine –smoking association remained significant after multivariate adjustment for demographics, socioeconomic status, PANSS (p =0.048).

Conclusions: Our study, limited by its cross-sectional design, suggests that decreased tyrosine may play a role in mediating or moderating the previously reported association of smoking and schizophrenia, and provides a rationale for further investigation including proof of concept tyrosine supplementation trials in selected subgroups of patients. .

P6-20
A LITERATURE REVIEW ON PREFRONTAL CORTEX DISEASE AND SOME TREATMENT OPTIONS: AN UNDERLYING LINK BETWEEN SUBSTANCE ADDICTION AND SCHIZOPHRENIA?

Lead Author: Anthony Kelada, M.D.

Co-Author(s): Jamsheed Khan, M.D.

ABSTRACT:
Background: The prefrontal cortex (PFC) is an integral part of everyday decisions. Due to its role in complex functions, it is nicknamed the chief executive officer of the brain due. The PFC is also a popular research topic in regards to addiction and drug abuse. Furthermore, schizophrenia is a debilitating psychiatric disorder that appears to have an association with the PFC.

Objective: This paper aims to review the literature on prefrontal cortex disease, how it relates to schizophrenia, and possible management options for schizophrenia patients with prefrontal cortical dysfunction.

Method: A literature review was performed by searching the by searching Pubmed and the local medical library using keywords such as: PFC anatomy and function, PFC dysfunction in schizophrenia, addiction, and prefrontal cortex treatment.

Results: The functions of the PFC correlate with many dynamic processes, ranging from goal-setting to working memory to emotions and social cognition. It is connected with every major region of the brain. Symptoms of prefrontal cortex disease syndromes include flat affect, a sense of indifference, and impulsivity. Although there have been conflicting results, studies have shown that hypometabolism in the PFC may correlate with negative symptoms of schizophrenia, and hypermetabolism of the PFC may correlate with positive symptoms. Nevertheless, it is evident that metabolic dysregulation in the PFC is found in schizophrenia. Also, the PFC plays a role in organizing behavior, such as an addict's drug-seeking ways. The PFC is also the site of action of novel pharmacological approaches to treating schizophrenia. Schizophrenia is a significant debilitating disease mainly due to cognitive dysfunction. New methods of treating this disease include: computer-based programing, cognitive behavioral therapy, social skills training, and online-based supportive systems.

Conclusion: Schizophrenia cases are difficult to treat, and cognitive dysfunction has profound implications on functionality. Breaking this down into specific aspects of disease may help with cognitive function in schizophrenia. For example, patients with verbal memory impairment will benefit from the computer-based learning program as described. Patients with problems in social functioning will benefit from Social Cognition and Interaction Training Program. Patients who need help in goal setting will benefit from SOAR. It appears feasible that PFC dysfunction is an underlying link for the high rate of addictive behavior in schizophrenia. Alluding to this, there are new drug studies on a family of receptors located in the PFC that show promising results in not only treating schizophrenia, but also eliminating drug-seeking behavior. Research suggests that an integrative approach with one provider focusing on medication management, elimination of substance abuse, and cognitive enhancement therapy to improve PFC function is the best means for establishing patient-centered care.

P6-21
ASSESSING THE RELEVANCE OF CONSUMER ENGAGEMENT AND INCENTIVE PROGRAMS IN A COMMUNITY-BASED MENTAL HEALTH SETTING

Lead Author: Raymond Kotwicki, M.D.

Co-Author(s): Kimberly D. Farris, PhD; Philip D. Harvey, PhD

ABSTRACT:
Background: Previous literature notes that significant numbers of individuals with severe mental illnesses are often difficult to engage in treatment services. Non-engagement

in community-based models of service delivery presents a major obstacle increasing risk for re-hospitalization/relapse. This is particularly important given the fact that many treatment interventions are limited in duration by insurance, meaning that immediate engagement may be required for optimal outcomes.

Methods: Skyland Trail's Milestones of Recovery Engagement Scale (SMORS) is an adaptation of the Milestones of Recovery Scale (MORS). This scale quantifies stages of recovery using range of milestones from complete disengagement to advanced recovery. The rating range from 1 to 6 and are generated by consensus reached between the primary counselor and treatment team. Patients who achieve a minimum threshold for a 4-week period are eligible for a financial incentive. All private pay families are eligible for the financial assistance award. Patients must receive a rating of 4.5 to "qualify" for assistance and consistently high ratings lead to an increased amount of assistance (up to 20%). Change in ratings to less than 4.5 leads to lowering assistance amount.

Results: Approximately 41% (N=133) of patients received financial assistance for at least one month during 2011, 18% for 2 months, 14% for 3 months, 20% between 4-6 months, and 7% between 7-9 months. Of the patients who achieved the milestone for a four week period, the risk of reductions in SMORS scores was minimal: 88% or more of the cases who received an incentive based on the first four weeks of treatment received SMORS scores in the qualifying range in weeks 5-8 of treatment. However, for cases whose first 4 week scores were less than the threshold of 4.5, less than 50% achieved that threshold on any of the subsequent 4 weeks of assessments.

Implications; Individuals who demonstrated significant engagement in treatment received financial incentives. These individuals were very unlikely to lose those incentives over time. However, lower scorers showed only about a 50% rate of increased engagement. Our interpretation of the results is that incentives can serve to sustain motivation of initially engaged cases with high levels of success, but there are a substantial proportion of cases where the provision of incentives does not lead to increased engagement. These cases likely require additional strategies to promote increased engagement in treatment.

P6-22
REDUCING RESTRAINTS: A PATIENT SAFETY, STAFF DRIVEN INITIATIVE

Lead Author: Drothy Kuntz

Co-Author(s): Lisa Lacy, Denise Bodish, Maryrose Dorward, Colleen Green, and Jane Halpin

ABSTRACT:
Purpose/Significance: Successfully reducing or preventing seclusion and restraint (S/R) requires leadership commitment, resource allocation, and new tools for staff to improve the patient experience. Substantial savings can result from effectively changing the organizational culture to reduce and prevent the use of S/R. This poster will detail successful S/R reduction efforts, led by a team of mental health nurses and supported by nursing leadership, in a 24 bed, acute adult behavioral health unit in an academic, community Magnet™ hospital.

Strategy/Implementation: Initially, staff focused their attention on early identification of triggers which tend to escalate patients into unsafe behavior. Patients are interviewed on admission and asked a variety of questions addressing aggression history, problem behaviors, triggers, warning signs, and interventions that help a patient regain control of their behavior. The information is placed on an easily accessible nursing Kardex so staff can intervene with sensory-based approaches should a crisis arise. A sensory cart is stocked with items such as classical music (sound), drawing/coloring books (sight), lavender, vanilla, and orange oil (smell), a stress ball, a weighted vest (touch), salty, sour, and sweet foods (taste). Engaging patients in emotional regulation through self-soothing and bringing the patient 'back to the moment' is the driving force behind the use of sensory modalities. A second effort to prevent S/R examined the current practice of responding to a psychiatric emergency. Instead of physically reacting to a situation, a hands-off focus is now utilized. "Watch and negotiate, rather than touch," is the new motto. The unit has an internal response team as well as a comprehensive crisis management team. Other positive changes include a patient safety card, completed with the assistance of a nurse, which identifies a safety plan and helps patients recognize their need to take responsibility of their behavior and maintain their own safety. This wallet-sized card is easily referenced and used post discharge. Additionally, a dedicated individual whose sole task is to perform 15 minute checks and identify early signs of behavior changes was implemented. Scheduling a specific person to be visually present makes patients feel safer and significantly decreases the number of patient safety reports. This person is deemed the eyes and ears of the unit. Finally, use of primary nursing provides consistency with treatment and ultimately raises a patient's level of trust.

Conclusion: Exploration and implementation of innovative interventions can be done very cost-effectively while positively impacting the patient experience. All initiatives discussed herein decreased the use of S/R on this 24 bed, adult behavioral health unit. According to evidence-based literature, people recover more quickly and experience greater success in the community when violence is extracted from the treatment setting.

P6-23
WORKING WITHIN INTEGRATED CARE: COMMON ISSUES AND CHALLENGES FOR PSYCHIATRIC CLINICIANS

Lead Author: Robert M. Levin, M.D., M.P.H.

ABSTRACT:
Integrated care of psychiatry and primary care is an increasingly important model in healthcare today. Hence, a tremendous opportunity exists for psychiatrists and behavioral clinicians to work with and educate medical clinicians. However, in spite of extensive literature and didactic resources on the relevant epidemiology, diagnostic screening, clinical outcomes, administrative, and financial aspects of Integrated Care, there's little discussion of common challenges - both clinical and professional - that behavioral clinicians will encounter.

Experience suggests there are specific aspects of integrated care that can be new and challenging for behavioral clinicians. This presentation will identify and discuss examples of such, with review of the relevant literature, followed by practical, user-friendly approaches and suggestions. It will address:

Aside from good clinical skills, what exactly do PCP's want and need from us? How does one 'translate' psychiatric knowledge so it's understood and helpful? Which psychiatric medications should PCP's be expected to use - all, or just some? What are essential risk management, documentation, and communication practices? PCP's identify an estimated 15% of their patients as 'difficult' - how can we help with their management? How should PCP's approach the suicidal or psychotic patient? What makes for optimal interdisciplinary teams? Which clinical issues and diagnoses necessitate referral to psychiatry, rather than informal or team discussion? And, Are there basic 'do's and don'ts' for psychiatric clinicians working as part of integrated care?

P6-24
PSYCHIATRIC READMISSIONS AT UC SAN DIEGO MEDICAL CENTER: DESCRIBING CHARACTERISTICS OF PATIENTS WITH 30-DAY READMISSIONS

Lead Author: Lawrence Malak, M.D.

Co-Author(s): Karina Vesco, MSW; Sidney Zisook, M.D.; Steve Koh, M.D., MPH, MBA

ABSTRACT:
Background: Psychiatric readmissions illuminate several potential areas where our mental health system break down, including access to medications, clinical services, housing and substance use treatments. Readmissions also represent a significant cost to our healthcare system and will be used by Center for Medicaid and Medicare Services as a performance outcome measure. In 2012, San Diego County generated a report looking at readmissions to psychiatric facilities with the goal to gain more insight into this group.

Objective: To describe the rates and characteristics of patients who are admitted and readmitted to UCSD Medical Center and compare these data with other San Diego County Psychiatric Facilities. Ultimately these data can help inform more effective interventions to reduce readmissions and improve patient's ability to maintain in the community.

Method: All admissions to the psychiatric unit at UCSD medical center from July 1,2011 to June 30, 2012 were extracted from the EMR and analyzed using SPSS 21.0. Groups were separated into a) single admission or no readmissions within 30 days b) those with a 30 day readmission, c) those with 4 or more readmissions. Characteristics such as age, gender, diagnoses, insurance, substance use and ethnicity were evaluated in all 3 groups. These characteristics and rates will be compared to the rates found in San Diego county and presented for discussion of possible future interventions.

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P6-25
LOW DOSE NALTREXONE-BUPRENORPHINE COMBINATIONS IN THE OUTPATIENT TREATMENT OF OPIOID ADDICTION: FEASIBILITY, SAFETY, AND PRELIMINARY RESULTS

Lead Author: Paolo Mannelli, M.D.

Co-Author(s): Kathleen Peindl, PhD; Li-Tzy Wu, ScD

ABSTRACT:
Objective: The administration of naltrexone in combination with buprenorphine may help expedite opioid detoxification and further induction to naltrexone treatment among individuals with opioid addiction (OA). Other clinical applica-

tions may stem from the predicted ability of naltrexone-buprenorphine combinations to reduce opioid dependence and cocaine use, and improve analgesia. Unfortunately the risk of significant enhancement of opioid withdrawal discomfort when the two medications are given together raises concerns and suggests the identification of safe methods of clinical use.

Methods: We examined treatment safety and tolerability, daily drug use, and opioid withdrawal intensity among 10 consecutive OA patients, in the initial 3 days of an open-label transition from opioid use to extended-release naltrexone injection (XR-NTX, Vivitrol). Individuals were administered buprenorphine/naloxone daily (4mg, 2mg, and 2mg respectively), and were equally divided into 2 groups receiving naltrexone 0.25/0.5mg (Day 1), 0.25/0.5mg (Day 2), and 0.5/1mg (Day 3).

Results: No drop-outs and adverse or serious adverse events were recorded. Opioid withdrawal intensity and craving scores were 50% to 80% lower than baseline following the first day of treatment, and were 70% lower than pre-treatment scores by Day 3. 77% of urine samples were negative for opioid substances following 3 days of treatment. Among OA patients who used cocaine in the week before treatment (n=5), negative urine tests results for cocaine were 86%, while negative opioid tests results amounted to 73%. There were no differences in treatment response associated with severity of opioid dependence, type or quantity opioid used, time elapsed between last opioid and induction to treatment, use of ancillary medications, or different naltrexone schedules.

Conclusions: The administration of naltrexone-buprenorphine combinations as described was safely performed in this group of patients, and was associated with reduced withdrawal intensity and reduced opioid and cocaine use. Further investigation in larger samples is needed to confirm the feasibility of this method and evaluate its place in the transfer of OA patients from opioid use to XR-NTX treatment.

P6-26
CANNABIS AND DRUG-DRUG INTERACTIONS

Lead Author: Reetta Marja Marciano, M.D., M.S.N.

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ABSTRACT:
Purpose: To examine the potential for cannabis and drug-drug interactions.

Background: Cannabis is one of the most widely abused drugs in the United States and is now legal to consume and prescribe in some states. It is unclear if enough data exists on drug safety to allow for responsible prescribing. Few studies address drug-drug interactions with cannabis. Some literature exist regarding the P450 microsomal enzyme and the glycoprotein pathway. This review mainly focuses on the potential drug-drug interactions within the P450 pathway.

Method: A PubMed search was conducted using the search terms: cannabis or THC and P450 enzyme, 2C9, 2D6, 3A4, and 2C9. After reviewing the resulting articles, the following terms were added to the search: delta 9-tetrahydrocannabinol, candesartan, irbesartan, losartan, fluoxetine, sertraline, chlorpromide, glimepiride, glyburide, tolbutamide, aceclofenac, diclofenac, ibuprofen,indomethacin, piroxicam, bosentan, dapsone, fluvastatin, mestranol,phenobarbital, phenytoin, tamoxifen, tetrahydrocannabinol, torsemide,S-Warfarin, CYP3A4, CYP4F2, CYP4F2, CYP4X1, CYP 2D6, P450 enzyme, and pain. Article limitations were English language, publication in the last 20 years, and location in peer reviewed journals. Both human and animal in-vitro studies were included.

Results: The initial search yielded 640 articles, 52 were accepted for review after relevance to drug metabolism pathways were determined. Fifty-two articles were reviewed by two reviewers and 12 were rejected, leaving 40. Cannabis compounds share many of the same metabolizing enzymes with antidepressants, antipsychotics, anti-anxiolytics, neoplastic agents, S-warfarin, inflammatory agents, and antimicrobials. Additional mechanisms of drug-drug interactions are the glycoprotein pathways.

Discussion: Cannabis and its many component substances interfere with the metabolism of prescription medications. The most well studied is its ability to inhibit activation of S-warfarin and anti-inflammatory drugs. Other mechanisms for drug-drug interaction include the P450 enzyme 2C9 along with CYP3A4, CYP4F2, CYP4F2, CYP4X1 and CYP 2D6 and glycoprotein mediated interactions.

Conclusion: Randomized, controlled trials are needed to examine the potential metabolic interactions between cannabis and other drugs and assess the clinical impact of these interactions.

P6-27
INSOMNIA AND CONDUCT PROBLEMS PREDICT SUICIDE IDEATION AND ATTEMPTS IN CHILDREN AND ADOLESCENTS WITH EATING DISORDERS

Lead Author: Raman Baweja, M.D.

Co-Author(s): Susan Calhoun, Julio Fernandez-Mendoza, Richa Aggarwal, Mariah Arnold, and Fauzia Mahr

ABSTRACT:
Objective: Frequency of suicide behavior in children and adolescents with bulimia and anorexia and risk and protective factors were determined.

Background: Studies show that insomnia and nightmares are associated with suicide ideation and attempts in adolescents and adults and that individuals with eating disorders are at risk for suicide behavior. Our study is the first to determine risk and protective factors in children and adolescents with eating disorders using sleep, psychological, and demographic variables.

Methods: Mothers rated suicide ideation and attempts in 45 outpatients (13 with bulimia and 32 with anorexia) ages 7-18 (M 14). Independent variables were (1) demographics (age, gender, race, and parent occupation), (2) eating disorder type and severity, (3) comorbid diagnoses, (4) 10 sleep variables (e.g., difficulty falling asleep, waking during the night, and nightmares), (5) somatic symptoms, and (6) maternal ratings on 15 psychological problems (e.g., bullied, anxious, sad, and impulsive).

Results: Suicide ideation was far more prevalent in bulimia (46%) than in anorexia (12%). All patients with bulimia who had ideation also had attempts, whereas no patients with anorexia had attempts. All patients with ideation or attempts had comorbid depression, anxiety disorder, oppositional defiant disorder, and/or ADHD. The 21 patients with anxiety plus depression had more ideation (38%) and attempts (24%) than patients with either anxiety or depression or neither (8% and 4%).

The strongest single predictor of ideation and attempts was sleep disturbance (insomnia and nightmares). 67% with sleep disturbance had ideation (vs. 6% without) and 42% had attempts (vs. 3% without). Classification accuracy using sleep disturbance alone was 87% for ideation and 82% for attempts. Two other variables that correctly classified 80% or more of patients with and without ideation and attempts were not getting along with peers and explosive. The most powerful combined predictors of ideation and attempts were sleep disturbance and specific conduct problems (explosive, does not get along with peers, bullies, and substance abuse). Classification accuracy for these combined predictors was 93% for ideation and 98% for attempts.

Ideation was not reported in any patients who were not defiant, sad, angry, or anxious. No patients with anorexia had attempts. Attempts were also absent in those who did not binge or purge and in those who were not impulsive, defiant, sad, angry, or feeling worthless. Although these features were necessary for ideation or attempts, they alone were not predictive and identified only a minority of patients with ideation or attempts.

Conclusions: All children and adolescents with eating disorders should be screened for suicide ideation and attempts, which are particularly prevalent in bulimia. Risk factors (sleep disturbance, peer relationship difficulties, and explosive) should be assessed and targeted for intervention to prevent suicide.

P6-28
HOUSING TRAJECTORIES AMONG AN URBAN, HOMELESS POPULATION WITH MENTALLY ILLNESS

Lead Author: Jarrell Collin Meier, M.D.

Co-Author(s): Matthew Lezama; Christina Mangurian, M.D.; James Dilley, M.D.; Martha Shumway, PhD

ABSTRACT:
The United States Department of Housing and Urban Development (HUD) estimates that roughly 636,000 people were homeless on a single night in January 2011 (1). Additionally, nearly one-quarter (24.9%) of sheltered individuals were reported to have severe mental illness (2). The 2011 San Francisco Homeless Point-In-Time Count identified 6,455 homeless individuals living on the streets and in the shelters of San Francisco (3). Due largely to its location, the South of Market Mental Health Clinic (SOMMHC) serves a diverse population of clients and is unofficially seen to be the primary homeless mental health clinic for the city. There is scant literature pertaining to interventions that address the intersection of homelessness, mental illness and race (4). Additionally, no housing trajectory studies have been conducted that take into account the influence of diagnosis, demographic variables, and follow-up with severely mentally ill homeless individuals at SOMMHC.

Methods: Data were collected through a retrospective chart review of 117 individuals who first presented to SOMMHC between January 2011 and December 2011. Progress notes were examined for one year after intake to assess each individual's monthly housing status as well as their utilization of services. Demographic information including race, gender, age, education level, and insurance status were recorded with each individual as were the Axis I-III diagnoses and Global Assessment of Function (GAF) scores. Data were then analyzed to identify the trajectory of housing status over time. Chi-square analyses and t-tests were used to determine how individual characteristics and utilization of services affected housing trajectories.

Results/Conclusion: The rates in which mentally ill homeless individuals obtain housing will be identified in this study. Core demographic variables, diagnosis and the documented level of follow-up with therapists, case managers, and medical doctors are assumed to contribute to this trajectory at SOMMHC.

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P6-29
SEXUAL ABUSE AND SUICIDE RISK: EVIDENCE REVIEW, FINDINGS FROM SECONDARY ANALYSIS WITH ADULT PSYCHIATRIC INPATIENTS, AND CLINICAL IMPLICATIONS

Lead Author: Michael Mitchell, M.A.

Co-Author(s): EA Youngstrom, A Hameed, RE Meyer, AJ Gelenberg

ABSTRACT:
Background/Introduction: Sexual abuse is a traumatic experience that can include serious psychological consequences such as suicidal thoughts and/or behaviors. Consistently across the research literature, a greater proportion of women report having a history of sexual abuse than men. However, biased item language and lack of systematic inquiry may contribute to lower prevalence rates for men and under-reporting of sexual abuse. Along parallel lines, clinical researchers have raised awareness toward methodological limitations with suicide assessment procedures.

Method: A total of 199 psychiatric in-patient adults participated in the original study. The sample was characterized as 57% women and 43% men. Study procedures were carried out as part of the original psychometric evaluation study comparing three different suicide assessment instruments. Assessment measures included the Columbia Suicide Severity Rating Scale to examine lifetime suicidal ideation and behavior. A comprehensive risk assessment interviewed collected various risk and protective factors with one item inquiring about lifetime sexual abuse ("Have you ever had any unwanted sexual experiences?").

Analysis: A secondary analysis from the clinical psychiatric sample was conducted in order to contribute to the existing literature on sexual abuse and suicide. The primary aim was to describe the proportion of sexual abuse victimization and report on gender differences. The research also examined for any relationship, and possible predictive utility between sexual abuse history and suicide risk.

Results: Approximately half of the clinical sample reported having a lifetime history of sexual abuse (45%, n = 90). Findings demonstrated significantly greater proportion of female patients indicated having a history of sexual abuse than males. The relationship between sexual abuse and lifetime suicide attempt was statistically significant for the entire sample. Further analysis revealed this relationship was statistically significant for men, but not for women. Results from the regression model revealed having a history of sexual abuse significantly predicted a history of suicide attempt. There was no significant interaction between gender and sexual abuse predicting lifetime suicide attempt.

Significance: Sexual abuse is a significant risk factor for suicidal behavior. While gender differences remained consistent with existing literature, approximately half of men in the psychiatric sample reporting a history of sexual abuse. Clinicians should sensibly, but also systematically, inquire about previous sexual abuse in psychiatric patients when assessing for suicidal risk behaviors.

P6-30
DEVELOPMENT OF A STANDARDIZED MEDICAL CLEARANCE FORM FOR A PSYCHIATRIC EMERGENCY CENTER

Lead Author: Nidal Moukaddam, M.D., Ph.D.

Co-Author(s): Matorin, Anu, M.D.; Shah, Asim, M.D.

ABSTRACT:
Background: There is considerable confusion and varying opinions in the literature regarding "medical clearance" of patients presenting to the emergency room with psychiatric complaints. Medical clearance serves two purposes: 1- ascertaining medical stability of patients in need of inpatient psychiatric care and 2- making sure that patients get appropriate treatment, in cases where psychiatric complaints are masking legitimate medical issues that require intervention. Different facilities have their own "exclusionary forms", a compilation of criteria that are required for a patient to be accepted to each facility. There is a need for a unified & standardized medical clearance form to facilitate flow between medical and psychiatric emergency rooms, units and optimize patient care and safety, while balancing financial constraints and avoiding unnecessary ancillary testing.

Methods: Exclusionary forms from twelve inpatients units that our psychiatric emergency center refers to most frequently were compared. Common factors were gathered in a new simplified medical clearance form. The form covers four areas: 1- capacity/consent 2- specific exclusion criteria for our psychiatry emergency center (administrative, forensic) , 3- acute medical conditions/findings and 4- patient medical requirements. This form was implemented starting August 2010 as the threshold for accepting patients into the psychiatric wing of the emergency center. Follow-up on form implementation were discussed at weekly quality assurance meetings.

Results: Usage of the new form was accompanied by a positive response overall by both psychiatric and medical staff in terms of mainstreaming and facilitating flow between the medical and psychiatric emergency centers. The use of this form has also facilitated transfer to outside inpatient psychiatric facilities. Confusion & implementation difficulty have arisen mostly for the acute medical conditions/findings category, most commonly for cases of altered mental status and elevated blood pressure.

Conclusions: Using the unified medical clearance form has allowed a smoother and more uniform patient flow between the medical and psychiatric emergency centers. It has proven especially helpful for trainees. Clearance of certain medical issues remains contentious, but having clear criteria has improved the ability to dialogue between different medical and psychiatric services.

P6-31
RETHINKING RESTRAINT AND SECLUSION: MAJOR DIFFERENCES BETWEEN CHILDREN AND ADULTS

Lead Author: Stephen Pappalardo, B.A.

Co-Author(s): David L. Pogge, Martin Buccolo, Philip D. Harvey

ABSTRACT:
Background: In a confined inpatient setting, agitated and dangerous behavior increases the risk of injury for the agitated patient, other patients, and staff members. This problem is compounded in situations where the reason for referral to inpatient care was agitation. Given current definitions of seclusion and restraint, any physical contact with a patient constitutes restraint and any instructions to go to a specific location constitute seclusion. Our hypothesis in this study was that seclusion and restraint would have very different characteristics in adult and child inpatients, with differences in the prevalence of these interventions, their duration, and their reoccurrence.

Methods: These analyses were collected on the basis of two years of inpatient admissions to a private psychiatric hospital. All of these incidents were recorded contemporaneously and these analyses were performed from medical records. As mechanical restraint was not used at this hospital, all restraints were physical restraints and seclusion included either being told to go to one's room or being escorted to a seclusion room in another location. For this presentation, we compared child cases to adult cases because of the clear differences in reasons for referral to the hospital. Further, we examine the proportion of cases where the restraint or seclusion was accomplished by a single staff member to the proportion of cases where additional assistance was required.

Results: Out of 749 child and 1093 adult cases, 441 had one or more seclusion events. Among these cases, the modal number of events was 1 (n=194). Child patients had a higher prevalence of events and a higher frequency of events (n=396, 53% M=11.5), with adults much lower (n=35, 3% m=3.3). There were notable differences in the types of seclusions experienced, with child patients largely experiencing in-room seclusion on the unit (9.2/11.5 events), while adult patients were much more likely to receive off-unit seclusion (2.9/3.3 events). Duration of physical restraint averaged 4 minutes for children and 22 minutes for adults, while the duration of on-unit seclusion averaged 25 minutes for children and 42 for adults. Off unit seclusion duration averaged 44 minutes for children and 69 minutes for adults. Interventions performed by a single staff member constituted 73% of the child events and only 6% of the adult events.

Implications: These data suggest that the frequencies and characteristics of restraint and seclusion are markedly different in child and adult inpatients. The majority of children and a very small proportion of adults experienced restraint or seclusion. The major differences between the frequency and topography of these events call into question whether they should be considered to be identical or even similar experiences.

P6-32
CHANGING CULTURES OF STATE PSYCHIATRIC HOSPITALS TO REDUCE CLIENT SECLUSIONS AND RESTRAINTS

Lead Author: Iman Parhami

Co-Author(s): Iman Parhami, M.D., MPH; Imran Trimzi, M.D.; Mary Diamond, D.O.; Susan Robinson; Gerard Gallucci, M.D.

ABSTRACT:
Background: The use of seclusion and restraint creates significant risks at psychiatric hospitals. These risks include death, serious injury, traumatization, and other psychological harm for patients and the staff administering the seclusion or restraint. In light of these potential consequences, some facilities continue to incorporate these methods apathetically and too often. The purpose of this report is to identify the strategies used to implement a pilot program aimed at reducing the utilization of seclusions and restraints

and present preliminary data assessing the trend of their use over time.

Methods: In 2008, the Delaware Psychiatric Center implemented a new pilot program aimed to reduce the utilization of seclusions and restraints in the hospital. From 2008 to 2012, the number of seclusions and restraints and associated adverse effects were recorded. Generalized linear models determined whether the number of seclusion and restraint incidents decreased over time.

Results: Strategies that helped implement this pilot program included revising the mission statement to incorporate trauma informed and recovery principles, providing new mandatory training for staff to learn alternative methods to deal with aggressive and agitated patients, removing security from front lines role in responding to codes, and creating comfort rooms. Preliminary results revealed a reduction in the number of seclusions (year: number of incidents; 2008:43; 2009:39; 2010:12; 2011:1; 2012:2) and restraints (2008:106, 2009:26, 2010:39, 2011:50, 2012:2). Analysis suggests a statistical significant reduction in the number of seclusion and restraints in this period. The number of adverse effects did not change over time.

Conclusion: The revealing downward trend of seclusions and restraints in this period imply the feasibility, practicability, and potential benefits from the implementation of this pilot program.

P6-33
PURSUING WELLNESS: ACHIEVING FALL REDUCTION THROUGH STAFF AND PATIENT PARTNERSHIP

Lead Author: Jaime Funk, R.N.

Co-Author(s): Lisa Lacy, Colleen Green, Jane Halpin, Nicole Urban-Miller and Katie Mercadante

ABSTRACT:
Purpose/Significance: Patient falls are a major cause of injury among hospitalized psychiatric patients, often prolonging and complicating their stay and impacting their well-being beyond hospitalization. A gradual rise in fall rates prompted nurses on a 52 bed, acute adult behavioral health unit in an academic, community Magnet™ hospital to translate new research into their fall prevention practices. This poster details the comprehensive fall prevention plan, which resulted in practices intended to impact patient safety beyond hospitalization.

Strategy/Implementation: One piece of the new fall prevention plan is a revised fall-prevention practice guideline, which involved a robust search of the evidence. As a result, a unique strategy within the guideline is a "fall" tab in the electronic documentation system containing all fall-related information in one easy to access location. Information includes the updated guideline, the Hendrich II Fall Risk Model, which our staff had been using and a new tool, the ABCS Injury Risk Assessment, which identifies additional patients at potential risk of fall injury. Use of the additional tool prompts nurses to think more critically and individualize a fall-prevention plan for each patient. Another key fall prevention strategy is a fall prevention contract, initiated on admission, in which the patient agrees to follow specific action items 100% of the time. This document prompts patients to make good and healthy choices. Other strategies in the revised guideline include: use of non-skid yellow socks; 'fall tips' posters in all patient rooms to educate about what causes falls and how to prevent them; a toilet rotation schedule incorporated into the patient rounding schedule; mandatory staff education; and staff safety huddles.

Conclusion: This data translates evidence into practice. New research shows patients who perceive engagement and involvement with both staff and their treatment programs experience a greater sense of value in their recovery. In turn, recovery well beyond hospitalization (and across the life span) is realized.

P6-34
MENTAL HEALTH SERVICES FOR LATINOS: A NEW ASSERTIVE COMMUNITY TREATMENT TEAM IN WASHINGTON, D.C.

Lead Author: C M Prasad, M.D., Ph.D.

ABSTRACT:
There is a growing need for a culturally sensitive approach for mental health care of Latin population in Washington, DC. Neighbors' Consejo is one such non-profit organization in Washington, DC for the past 19 years. The clients are mentally ill and alcohol/substance dependant patients. Almost all of its clients are Unemployed, Homeless, Illegal, have legal problems, mentally ill and have Alcohol/Substance dependence problems. This facility also accepts Hispanic consumers from various other agencies like courts, jail diversion programs, immigration and other agencies. Neighbors' Consejo provides treatment and case management services to these clients.

There are 16 Assertive Community Treatment (ACT) teams in the Washington, DC to serve the mentally ill clients. However, they are not able to provide culturally sensitive treatment for the Latin population. Specifically, speaking in Spanish with the clients and to understand the needs of this section of population is the key for successful communication with and treatment of the Hispanic clients in crisis. Neighbors' Consejo has bilingual staff and is the only residential as well as an outpatient treatment center in Washington DC . Neighbor' Consejo is also a core service agency of the Department of Mental Health of the District of Columbia. Neighbors' Consejo is initiating a Latin ACT team as an experimental model to serve these consumers and to address the culturally sensitive social issues in a large city like Washington DC.

P6-35
POST-STROKE PSYCHOSIS

Lead Author: Muhammad Puri, M.D., M.P.H.

Co-Author(s): Muhammad Arif, M.D.,

ABSTRACT:
Psychosis is a severe mental disorder characterized by disorganized thought process, disorientation in time and space, hallucination and delusion. Psychosis is a relatively rare complication of stroke with reported prevalence of only 1%(Levenson 2007;ohara et al.2006). Stroke is not only cause the physical and cognitive impairment, it also cause the many psychiatric problems.The most common neuropsychiatric problem is the depression (Chemerinski &Robinson 1999).This report will describe the correlation between lesion location and the development of post stroke neuropsychiatric manifestations; it may also provide some helpful suggestions regarding the diagnosis and treatment of the psychotic symptoms observed in stroke.

A 78 year old Caucasian woman presented with psychosis and has a history of transient ischemic attack, hypertension, hypothyroidism and dyslipidemia and presented with acute psychosis.

P6-36
THE ASSESSMENT AND MANAGEMENT OF AGITATION AND DELIRIUM

Lead Author: Muhammad Puri, M.D., M.P.H.

ABSTRACT:
Mr. A, a 50-year-old man, brought to the emergency department. His vital signs were a heart rate of 88 beats/min, a blood pressure of 190/120 mm Hg, a respiratory rate of 14 breaths/min, an oxygen saturation of 98% on FIO2 100%, and a temperature of 98°F. He was 5 ft tall, weighed 110 lb. A neurologic examination was nonfocal; Mr. A's eyes were midline and his extra ocular muscles showed full range.

His laboratory studies were significant for a white blood cell count of 12,000 with 90% neutrophils. A comprehensive metabolic panel, liver function tests, urinalysis, were all unremarkable, Utox was positive for opoids, benzos. A noncontrast computerized tomography scan of the head revealed multiple, small hemorrhagic contusions within the right parietal and bilateral inferior frontal lobes with minimal surrounding edema.

Mr. A's medical history included hypertension. His psychiatric history was remarkable for psychotic disorder nos. Treatment involved use of nimodipine for bleeding prophylaxis. Mr. A was transferred to the surgical intensive care unit (ICU) for further treatment.

On neurologic examination, cranial nerves II-X were intact. His cognition remained impaired. He had periods of relative clarity and incoherent speech, as well as periods of over sedation and agitation, especially at night. He frequently pulled at his IV lines, and he removed his Foley catheter 3 times before he was adequately restrained with 2-point soft restraints. On hospital day 6, he received 1 dose of haloperidol (10 mg IV) for agitation; this was modestly effective, but his QTc lengthened (from 459 ms to 584 ms). Haloperidol was discontinued. When he became agitated later that day, he received olanzapine (5 mg); its use was not associated with QTc prolongation (his QTc ranged between 420 ms and 450 ms); olanzapine decreased his agitation. The psychiatry department was then consulted.

The psychiatric consultant found Mr. A sleeping in 2-point restraints. He was easily arousable and intermittently confused. He was unable to state his location or to recount the events that led to his hospitalization; he identified his location as a hospital when provided with choices. His speech was soft and slurred, and it was fluent with normal prosody (emotional melody and tone of language); however, he made frequent paraphasic (substitution of an inappropriate word) errors. He said his mood was "happy," and he appeared inappropriately bright. He responded appropriately to some direct questions but at times would respond with answers unrelated to the questions asked. He was oriented to person but not to the month or year.

A diagnosis of delirium was made. Contributing factors were thought to include anxiolytic, opioid withdrawal and hypertensive crisis. The following case vignette and discussion provide the forum for answers to these and other questions related to the differential diagnosis, the assessment, and the treatment of agitation in delirium.

P6-37
DIFFERENCES IN THE IMPLEMENTATION OF AOT (ASSISTED OUTPATIENT TREATMENT) IN NEW YORK CITY

Lead Author: Sasha Rai, M.B.B.S.

Co-Author(s): Charles W. Luther, M.D.; Jason E. Hershberger, M.D.

ABSTRACT:
Introduction: Assisted Outpatient Treatment (AOT) or Kendra's Law is a New York state law passed 12 years ago. AOT petitions are filed at vastly different rates by different

mental health systems. This project attempts to quantify those differences.

Methods: Data was obtained from the NYC DOHMH regarding the total number of AOT petitions filed from 1999 to 2010 by each mental health system (private hospitals, public hospitals and state hospitals) and that was compared to the total number of inpatient psychiatric beds available at each of these health systems. Furthermore the staff resources were compared between four hospitals representing these health systems.

Results: Public, private and state hospitals represented 23%, 33.3% and 43.6% of the total inpatient psychiatric beds respectively and accounted for 56.3%, 21% and 22.6% of all AOT initial petitions filed from 1999 to 2010 respectively. 97% of all petitions filed were granted AOT. The DOHMH filed mostly renewals of existing AOT petitions. Both Public and State hospitals had legal and staffing costs defrayed by the government unlike the private hospitals.

Conclusion: The authors recommend funding private hospitals systems for the costs of filing AOT petitions to better serve the severely mentally ill cared for in that setting.

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P6-38
CHALLENGES IN REFERRAL TO A NONINTEGRATED HIV PSYCHIATRY CLINIC AT AN ACADEMIC MEDICAL CENTER

Lead Author: Keith Reitz, M.D.

Co-Author(s): Isabel Schuermeyer, M.D.

ABSTRACT:
Integrated clinics that combine Psychiatry with Medical Subspecialty clinics have previously been shown to improve quality and outcomes in medicine. Clinics Integrating HIV care with Psychiatric, Hepatitis C, Psychological, and Social Services have been shown to improve viral suppression rates. The rate of psychiatric illness among HIV positive persons has been shown to be greater than that within the general population, though with varying estimates of prevalence. Depression and suicide rates are more than double that of the general population. This research was performed because an integrated HIV / Psychiatry care setting is not always feasible to implement, and it is necessary to evaluate barriers to care in the traditional setting.

Method: A psychiatric presence was created within the HIV Clinic via an elective resident rotation. Familiarity with psychiatric services offered within Psychiatry Department was promoted during a 1 month rotation in Jan 2012. Following completion of this rotation, the resident facilitated urgent on-campus referrals for standard psychiatric care. Referrals included standard psychiatric evaluation by resident and staff psychiatrist, medication management, and referrals within the Psychiatry department for psychotherapy services. Patients were followed within the psychiatric department for routine care.

Results: A total of 13 outpatient referrals were made from 3/2012-11/2012. Of 13 referrals, 6 scheduled and completed appointments and all continue to follow with psychiatry. PHQ-9 was administered upon initiation of psychiatric care, with mean score 16.3 (range 10-21). Most common reasons for referral were substance abuse and depression. Most common diagnoses among patients completing visits were Major Depression and Generalized Anxiety Disorder.

Conclusion: Non-integrated care is associated with poor visit completion rates in outpatient setting. Although this is a small sample size, it may be inferred that visit completion rates may benefit from proximity in location and scheduling offered by an integrated care setting. Further study is warranted.

P6-39
TEXT MESSAGE REMINDERS TO IMPROVE TREATMENT ENGAGEMENT IN PSYCHIATRIC SERVICES

Lead Author: Harpreet Kaur Sanghara, B.Sc., M.Sc.

Co-Author(s): Katie Bogart, BSc, MSc, MBPsS; Sherianne Sook Kuan Wong, BSc (Hons), MSc.

ABSTRACT:
Failure to engage with psychiatric treatment results in adverse clinical outcomes and significant financial loss to the NHS in England. Text messaging has been effective in improving engagement with health services and clinical outcomes in patients with physical illness. The feasibility of using this service with mental health patients was investigated in the course of three successive studies in a large NHS Foundation Trust in England.

In the first study, Sanghara, Kravariti, Jakobsen et al (2010) reported findings from a trust wide survey which revealed that 62% of inpatients with psychosis owned mobile phones and knew how to text, while 80% were willing to utilise this as a method of communication with clinicians on discharge from hospital. The second study was a large naturalistic observational study in four community mental health clinics, which revealed that text messaging led to a relative risk reduction in the Did Not Attend (DNA) rates of 25-28%, suggesting a time, labour and cost efficient strategy for encouraging engagement (Sims, Sanghara & Hayes et al, 2012).

The third study explored the feasibility of including text message medication reminders in the aftercare plan of users who are discharged from inpatient psychiatric units on maintenance antipsychotic medication, and to make evidence-based recommendations on their use. In this study, 82% of inpatients who were prescribed regular oral antipsychotic medication reported having a mobile phone, and nearly as many (80%) reported knowing how to use text messaging. A smaller majority (59%) expressed an interest in receiving text message medication reminders after being discharged from the ward. No demographic or clinical variable predicted expressed interest in receiving SMS medication reminders. Mobile phone ownership, intentional or unintentional non-adherence, perceived sufficiency of information on medication, and attitudes towards antipsychotic treatment also failed to predict interest in receiving SMS medication reminders.

The work conducted by this Greater London Trust suggests that mobile phone text message reminders are acceptable to patients, feasible for inclusion in large scale trials and effective in at least reducing non-attendance. However the precise role of text messaging in medication adherence requires further investigation, as forgetting is not the only reason for poor medication adherence.

P6-40
PSYCHIATRY RESIDENT TRAINING IN SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) FOR ALCOHOL AND SUBSTANCE USE DISORDERS

Lead Author: Asim Shah, M.D.

Co-Author(s): Christopher D. Martin, M.D.; James H. Bray, PhD; Alicia Kowalchuk, DO; Vicki Waters, MS, PA-C; Larry Laufman, EdD; Elizabeth Hodges Shilling, PhD; Ygnacio Lopez III, MS, MS

ABSTRACT:
Background: Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based approach to initiate addressing alcohol and substance use disorders with patients. There are growing efforts to incorporate SBIRT into postgraduate medical education. With SAMHSA grant support, SBIRT training has been incorporated into the psychiatry residency curriculum at Baylor College of Medicine since 2010.

Methods: First-year psychiatry residents receive four hours of SBIRT training that includes didactic presentations, video demonstrations, and interactive practice based on the Transtheoretical Model of Change and Motivational Interviewing; Residents were taught to apply SBIRT skills in multiple clinical venues and provided information about referral procedures. Faculty and resident "champions" receive a more in-depth three-day SBIRT training emphasizing Motivational Interviewing and addiction medicine. Residents and champions complete a baseline survey at the end of training and a similar follow-up survey one month after training. The surveys ask participants to rate items related to the quality and usefulness of the training on a Likert scale from 1 (most "positive" response) to 5 (most "negative" response). Additional automated monthly Web-based surveys are completed to capture self-reported numbers of patients provided any level of SBIRT services over the previous 30 days.

Results: Two Department of Psychiatry faculty and 34 residents have received SBIRT training. Eighty percent of participants have completed baseline and follow-up surveys. At baseline, residents were Satisfied to Very Satisfied (M = 1.69, SD = 0.838) with the training and indicated training enhanced their skills (M = 1.48, SD = 0.893). Ratings remained stable on the follow-up survey one month later (M = 1.68, SD = 0.945; M = 1.58, SD = .089) except for a statistically significant decrease in ratings for "usefulness of information," with M=1.36 (SD=0.700) at baseline to M=1.62 (SD=0.752) at follow-up (p=0.011). Despite the decrease, trainees remained Satisfied to Very Satisfied. At follow-up, 32 participants (84.2%) reported applying what they had learned in clinical practice. Over the past 21 months, residents and champions have reported using some level of SBIRT with 51.9% of their patients.

P6-41
"AND THEN I WOKE UP IN JAIL": AMNESIA CLAIMS IN COURT-ORDERED EVALUATIONS

Lead Author: John Shand, M.D.

Co-Author(s): John Preston Shand; Renee M. Sorrentino, M.D.; George W. Schmedlen, PhD, JD

ABSTRACT:
Introduction: Although the majority of people who are accused of crimes are able to give some account of the events surrounding an alleged crime, there are many defendants who claim interrupted memory which overlaps all of or parts of an alleged crime. This descriptive pilot study seeks to examine the characteristics of defendants who claim amnesia. In agreement with previous literature, we expected claims of amnesia to be fairly common in the population of people sent for evaluation to a court psychiatric clinic. Based on clinical experience, we also expected that claims of

amnesia would rarely impact competency.

Method: Data was obtained from (n=168) court cases from the Cuyahoga County Court Clinic in Cleveland Ohio for which amnesia was claimed for all of or part of an alleged crime. Sanity and competency reports from 2001-2011 were searched for the term 'amnesia' and included in the study if the defendant claimed amnesia for any part of their crime. Data about the defendant was then extracted from the court documents, including: age; sex; crime; Axis I and II diagnoses; substance use; type of amnesia claimed; legal history; history of traumatic brain injury; relationship to victim and psychological testing. The data was then analyzed to assess for commonalities.

Results: Defendants claiming amnesia had a mean age of 36 years, and were primarily male. The majority were facing charges for violent felonies, and claimed full amnesia for the crimes. Most defendants had a legal history. Most were opined by psychiatric examiners to be competent to stand trial, despite their alleged amnesia, and had substance use disorders.

Discussion: Offenders who claim partial or total amnesia for their crimes are not rare; 20-45% of individuals charged with a serious crime claim amnesia. The crimes most frequently associated with claims of amnesia are homicide and to a lesser extent domestic violence, sexual offenses and fraud. This study more fully describes the characteristics of those defendants claiming amnesia, who are ordered by the courts for evaluation, as well as establishing that the amnesia often did not lead to findings of incompetency. Further studies in this area would be helpful in the understanding the decision-making in competency evaluations with amnestic defendants.

P6-42
A REALIST REVIEW OF THE EFFECTIVENESS OF THE MOBILE CRISIS INTERVENTION TEAM (MCIT) PROGRAM

Lead Author: Gilla Shapiro, M.A., M.P.A., M.P.P.

Co-Author(s): Patricia O'Campo, PhD; Vicky Stergiopoulos, MSc, M.D., MHSc, FRCPC.

ABSTRACT:
Background: Police interaction with Emotionally Disturbed Persons in crisis situations can be costly in both human and economic terms. A number of programs have therefore been developed to prevent escalation and injury to both individuals in crisis and the police. One model that is transforming psychiatric practice, particularly in Canada, is the Mobile Crisis Intervention Team (MCIT) program. In the MCIT program, teams are part of, and have an integrated relationship with, both local community mental health services and the police department.

Objective: There has not been a review of the MCIT program and there is little shared evidence on how the MCIT program works and the critical elements of the program. There is a significant need for a high-quality evidence-based research synthesis to inform policy.

Methods: A realist review was conducted in order to provide a multifaceted understanding of what works, for whom, in what circumstances, and why. Both the academic and gray literature on the MCIT program were reviewed by accessing medical and social science databases as well as electronic reports. The search terms that were used were 'mobile crisis intervention team' as well as 'police or law enforcement' combined with 'psychiatric nurse', 'crisis intervention', or 'crisis team'.

Results: The results of this systematic review are synthesized and the outcomes as well as the critical elements of the MCIT program are reported.

Discussion: The relevance of these findings for researchers and practitioners are discussed. In addition, gaps in the literature and further research directions are identified.

P6-43
BOWEL OBSTRUCTION IN A PATIENT PRESCRIBED QUETIAPINE AND CHLORPROMAZINE: REITERATION OF NONMALEFICENCE, HOW TO AVOID CLINICAL AND LEGAL PITFALLS?

Lead Author: Humaira Shoaib, M.D.

Co-Author(s): Mahreen Raza M.D, Atika Zubera, M.D, Najeeb Hussain M.D

ABSTRACT:
Objectives: 1- To learn and to educate physicians more about antipsychotics effects on gastrointestinal motility; 2- Ongoing management of constipation in patients who require antipsychotic medications for stabilization on a long term basis; 3- To educate patients about better bowel habits, promoting beneficence and avoiding maleficence; 4- Legal pitfalls of this lethal side effect.

Method: Case presentation and literature review

Results: We have studied an interesting case that we encountered in Psychiatry Service of University Hospital. This is a 42 years old African-American man with history of Paranoid Schizophrenia. His psychotic symptoms were resistant and due to that he received multiple antipsychotic medications which resulted in severe constipation. Because the symptoms remained untreated he developed Bowel Necrosis leading to obstruction. Patient eventually had an emergent Decompressive Laparotomy, Total Colectomy, resection of his terminal ileum and ileostomy was created. This dilemma needs to be clarified and should be clearly defined that "who does what?"

Conclusions: This is the case of utmost importance and a great learning opportunity from educational point of view. Exploration about antipsychotics, it's anticholinergic effects in gastrointestinal tract and what could be done to minimize the anticholinergic effects should be the priority in patient who is on antipsychotic medications. Monitoring of the symptoms should be part of routine assessment.

We are hoping that by implementing these guidelines we can prevent bowel obstruction in patients who require antipsychotic medications.

P6-44
PATHWAY OF DEVELOPMENT OF PSYCHOSIS AMONGST CANNABIS ABUSING INDIVIDUALS: TOWARD A MODEL FOR TRAJECTORY

Lead Author: Amresh K Shrivastava FRCPC, D.P.M., M.D.

Co-Author(s): Megan Johnston, Kristen Terpstra, Yves Bureau

ABSTRACT:
Cannabis has been implicated as a risk factor for the development of schizophrenia, however, but the pathway of cannabis causing psychosis is not well understood. It appears that cannabis does not cause any structural changes per say but deficits in areas of the brain responsible for memory and emotion do show some changes. Recent studies suggest that cannabinoids such as CB1 have a pharmacological profile similar to that of atypical antipsychotic drugs. This mechanisms may involve dopamine, GABA, and glutamate neurotransmission; It is still not known if these changes are transitory or permanent, and whether or not they contribute to the pathophysiology of schizophrenia.

In this presentation we propose a hypothetical model to explain pathways of development of psychosis

P6-45
CARDIAC REPOLARIZATION- RELATIONS TO EXECUTIVE COGNITIVE FUNCTIONING IN THE SWEDISH WORKING POPULATION

Lead Author: Cecilia Ulrika Dagsdotter Stenfors, M.A.

Co-Author(s): Cecilia Stenfors,Lars-Göran NilssonTöres Theorell,Inga Jonsdotter,Walter Osika

ABSTRACT:
Background: Otherwise healthy persons in the work force may at times experience cognitive symptoms, such as difficulties in focusing attention, thinking clearly, in remembering adequately and in making decisions in their jobs and elsewhere. We have previously shown that cognitive symptoms in the working population is related to lower ability in executive functions required in working memory tasks. However, it is not known whether this lower cognitive ability is linked to physiological stress/allostatic load. As sympathetic activity is a key component in both dynamic and cumulative stress responses, the aim of the current study was to test the relation between measures of autonomic regulation of sympathetic activity- cardiac repolarization variability (QTVI)- and cognitive functioning, using cognitive tests that are sensitive to effects that are caused by stress.

Method: 233 (116 cases) male and female participants were drawn from the general gainfully employed Swedish population (from the Swedish Longitudinal Occupational Survey of Health) reporting either a high or a low level of cognitive symptoms. For all participants, ECG recordings and neuropsychological testing covering different cognitive domains, including executive functions, were performed.

Results: In women, but not in men, cardiac repolarization variability was related to poorer ability in executive functions that are required in working-memory tasks while being unrelated to others, after controlling for demographical factors.

Conclusion: Autonomic dysregulation of sympathetic activity may be both partly driven by- as well as negatively affect- poor executive cognitive ability. These factors may together drive the development of hypertension among women in the working population.

P6-46
CHARACTERISTICS OF PSYCHIATRISTS WORKING WITH THE HOMELESS

Lead Author: Jessica Thackaberry, M.D.

Co-Author(s): Steve Koh, M.D. MPH MBA; Sidney Zisook, M.D.

ABSTRACT:
The homeless population in the United States numbers into the millions. While in 2010, 1.59 million people stayed in emergency shelters or transitional housing, these estimates do not account for those who avoided the shelter system (1). It is well documented that mental illness, substance abuse, chronic illness are all prevalent in the homeless population (2). Additionally, those who are homeless are three to four times more likely to die prematurely compared to those who are domiciled (3). When taken into account that public mental health patients have increased mortality rates (4), the homeless with mental illness are a vulnerable subgroup.

Beginning in 2014, the Affordable Care Act (ACA) will

expand Medicaid to a large portion of the population. This will increase the potential healthcare coverage of the homeless population, but does not guarantee access to mental healthcare if there is a shortage of providers willing to work with the homeless. Some studies have looked at medical student and residents' perspectives on mental illness and the likelihood of volunteering to help the homeless (5, 6). These do not assess whether psychiatry trainees would work with homeless individuals or determine the possible factors that led psychiatrists to choose to work with the homeless.

To answer these questions, we present results of a survey looking at potential factors associated with psychiatric residents considering work within the community setting. To further understand the decision to work with the homeless, we interviewed psychiatrists working within community settings to collect qualitative data. We hope to foster continued research looking at increasing the number of psychiatrists working with homeless populations.

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P6-47
INCREASING THE RESILIENCE OF PRIMARY CARE CLINICS IN COMMUNITIES PRONE TO SUCCESSIVE MAN-MADE AND NATURAL DISASTERS.

Lead Author: John Hay Wells II, M.D.

Co-Author(s): Howard J. Osofsky, M.D., Ph.D.; Anne Ciccone, Psy.D.

ABSTRACT:
Under the Louisiana Mental and Behavioral Health Capacity Project, part of the Gulf Region Health Outreach Project, we are providing supportive collaborative services to primary care clinics in under-resourced communities exposed to successive complex traumas such as man-made and natural disasters. An ignored aspect of collaborative services is the potential disruption caused by the exposure of pent-up demand. Part of the service we offer is a strengthening of "clinical resilience"; by offering support in multiple domains such as on-site psychiatric and psychological treatment, telemedicine, and telephone consultation, we increase resilience by linking the clinical staff into a web of peer resources in an active process which reinforces the clinic's internal strengths by decreasing their perception of being isolated and under-resourced, and by providing them with a practiced and familiar communion to appropriate knowledge and decision support. This approach is in contrast to the traditional "crisis manual" approach in which a static plan is developed and shelved until disaster strikes. We will review our experiences developing this model of resilience in the field and discuss its application in various scenarios.

SYMPOSIA

THURSDAY OCTOBER 10, 2013

SYMPOSIUM 01

STATE PSYCHIATRIC HOSPITALS: TRANSFORMATION AND FUTURE

Chair: Alan Q Radke, M.D., M.P.H.

Discussant: Thomas (Ted) E. Lawlor, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Articulate an overview of state hospitals in the United States; 2) Identify the special state hospital issues; 3) Describe the future trends for state hospitals.

SUMMARY:
For a long time, state psychiatric hospitals were the mental health system. Derived from Europe's insane asylums, psychiatric hospitals in the United States began as a refuge for a mix of people, including those suffering from mental illnesses, with developmental disabilities and in poverty. These "State Psychiatric Hospitals' gradually clarified their role as serving persons with severe mental illness. With deinstitutionalization, state hospitals were downsized and underwent enormous change. Unfortunately, the community mental health system did not grow in proportion to the need of those discharged. A period of neglect ensued. Recently a period of relative attention and stabilization has developed. State hospitals are now in a time of searching for their future. While state hospitals have large commonalities, their current and future roles will differ significantly, driven by national, state and regional forces that will dictate their evolution. In this symposium we will discuss that transformation and the future of state hospitals.

S01-1.
STATE HOSPITALS FUTURE

Presenter: Alan Q Radke, M.D., M.P.H.

SUMMARY:
Presenter will discuss possible futures of state hospitals to include specialty psychiatric hospitals, community-based behavioral health hospitals and integration in regional service networks.

S01-2.
STATE HOSPITALS TRANSFORMATION

Presenter: Rupert R. Goetz, M.D.

SUMMARY:
Presenter will discuss transformation of state hospitals from asylums to state institutions to community-modeled hospitals.

S01-3.
STATE HOSPITALS TODAY

Presenter: Thomas (Ted) E. Lawlor, M.D.

SUMMARY:
Presenter will discuss the current state of state hospitals.

SYMPOSIUM 02

PSYCHIATRIC LEADERSHIP IN THE BEHAVIORAL HEALTH HOME

Chair: Lori E. Raney, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the regulations, definition and components of a behavioral health home; 2) Describe the skills that a psychiatrist needs to develop to effectively participate in health home teams and appreciate the contribution of psychiatric leadership ; 3) Comprehend team based care tasks in heath homes that lead to desirable outcomes, including population based data analysis to guide population-based treatment recommendations; 4) Describe current models of care that meet the spirit and intent of a behavioral health home while appreciating the ongoing potential for innovation.

SUMMARY:
Healthcare reform is sweeping the nation with new models of care that wield the promise of the Triple Aim: better outcomes, better experience of care and cost containment. One of the components of the Affordable Care Act is the expansion of health homes to include "one serious mental health condition" in the definition of allowable diagnoses for health home recognition and funding. Many state public mental health agencies are moving forward to implement health homes under this rule and receive the additional funding allowed to provide this enhanced system of care.

While the Joint Principles of the Patient Centered Medical Home stipulate each patient will have a "personal physician" and a "physician-directed care team", it is less clearly defined who will play the crucial role of directing patient centered care in public mental health settings. The most obvious candidate for this role in public mental health settings, by virtue of credentials and training, is community psychiatrists. However, like many projects pushing the leading edge of innovation, this can seem quite daunting for the profession given the lack of understanding and training in implementing these models.

This Symposium aims to begin articulating the knowledge and skill set psychiatrists need to competently and effectively engage in leading these teams in behavioral health homes. Ben Druss, MD will provide an overview of Behavioral Health homes, Joe Parks, MD will describe the Missouri model of health home implementation, Kathy Reynolds, LCSW will discuss examples of psychiatrist leadership in Primary Care Behavioral Health Integration grantee sites and Lori Raney, MD will provide a description of leadership in a health home initiative in Colorado.

S02-1.
DESIGNING A HEALTH HOME IN RURAL COLORADO

Presenter: Lori E. Raney, M.D.

SUMMARY:
Cortez Integrated Health Care is a uniquely designed facility that merges elements of a former community mental health center with a state of the art primary care facility. Dr. Raney will describe the first year of operation of this clinic including operational challenges, program development, issues in merging cultures and the role of psychiatric leadership.

S02-2.
LESSONS LEARNED FROM THE PBHCI BI-DIRECTIONAL INTEGRATION GRANTEES

Presenter: Kathy Reynolds, M.S.W.

SUMMARY:
With 94 sites across the country funded to bring primary care into the behavioral health setting the learnings on starting to pour in. Improvement in health outcomes, psychosocial outcomes and system reforms are standard across sites. This presentation will review what's being learned and the role of the psychiatrist in these outcomes.

S02-3
MISSOURI CMHC HEALTH HOMES

Presenter: Joseph J. Parks, M.D.

SUMMARY:
In January 2012 Missouri implemented CMHC Health homes state wide. Dr. Parks will describe the health home team structure, service delivery model, IT tools for care coordination and disease management, and financial model. Missouri CMHC Health homes provide care coordination, care management, management of care transitions, health promotion, individual and family support, and referral to community services for mental illness, SA, and chronic medical illness. Missouri CMHC are specifically designed to intervene in the diseases and risk factors responsible for premature mortality in persons with serious mental illness. One year clinical and financial outcomes will be presented.

S02-4.
BEHAVIORAL HEALTH HOMES: IMPLICATIONS FOR THE PSYCHIATRIC WORKFORCE

Presenter: Benjamin G. Druss, M.D.

SUMMARY:
The concept of a behavioral health home --a health home for people with serious mental illness based in a specialty mental health settings --is a recent one. The role for the mental health workforce, and psychiatry in particular, remains unclear. This presentation will provide an overview of the history of, and evidence base for, behavioral health homes. In particular, it will focus on potential roles for psychiatrists in these settings, and competencies they will need to fulfill these roles.

SYMPOSIUM 03

RECOVERY-ORIENTED COGNITIVE THERAPY: FROM THE LABORATORY TO THE STATE MENTAL HEALTH SYSTEM

Chairs: Aaron T. Beck, M.D., Authur Evans, Ph.D.

Discussant: Authur Evans, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the manner in which cognitive therapy promotes recovery; 2) Describe the basic research supporting the Recovery-Oriented Cognitive Therapy (CT-R) model for poor functioning in schizophrenia; 3) Identify components of CT-R milieu training for inpatient and outpatient psychiatric services; 4) Describe the way in which CT-R can be used by non-therapists; 5) Describe three challenges and their solutions of implementing CT-R in a state hospital.

SUMMARY:
Recovery-based care has become a mandate for mental health care providers in the United States.1-3 However, it may not always be clear to care providers how to translate recovery principles into concrete steps to facilitate recovery for individuals with schizophrenia.4 An approach to this problem is Recovery-Oriented Cognitive Therapy (CT-R), a treatment that fuses the Recovery movement's spirit5 and cognitive therapy's evidence base6 to collaboratively help individuals with persistent schizophrenia attain personally set goals, remove obstacles to their goals, and engage in their own psychiatric rehabilitation. This symposium will consist of four talks that introduce CT-R and describe a series of dissemination and implementation projects across the gamut of community mental health. Each of the speakers will present research or program evaluation data.

In the opening talk, Grant and Beck will introduce a new formulation that identifies dysfunctional beliefs as key contributors to low functioning in schizophrenia. They will describe research that supports the model, introduce the basic therapeutic approach of CT-R, present results of a clinical trial supporting the efficacy of CT-R, and give an overview of the dissemination and implementation of CT-R in community mental health. Creed et al., in the second talk, will describe dissemination and implementation of CT-R within a major metropolitan behavioral health care system. They will describe specialized CT-R programs for peer specialists, case managers, therapists, the outpatient therapeutic milieu, full Assertive Community Treatment (ACT) teams, and the creation of a therapeutic milieu in an acute inpatient service. In the third talk, Brinen et al. will discuss implementation of CT-R into a state hospital system. They will present the key personnel model of implementing CT-R. Grant et al., in the fourth talk, will present details of the implementation of CT-R in to a state behavioral health system. Training is simultaneously provided to hospital staff, community therapists, and ACT teams in order to promote continuity of care and maintain individuals with persistent schizophrenia in the community. Dr. Evans will lead the discussion at the end, emphasizing challenges overcome in producing recovery-oriented services in community mental healthcare.

S03-1.
DISSEMINATION AND IMPLEMENTATION OF RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R) IN INPATIENT AND OUTPATIENT COMMUNITY-WIDE MENTAL HEALTH SERVICES

Presenter: Torrey A, Creed, Ph.D.

SUMMARY:
Recovery-based care requires tailoring to the specific treatment setting, provider, and person in recovery. We report a series of CT-R dissemination and implementation projects within a major metropolitan area. These projects aimed to establish a CT-R treatment milieu in an acute inpatient psychiatric unit, an outpatient community behavioral health center, and on several ACT teams, respectively. In each setting, workshops and onsite consultations helped trainees learn CT-R theory, strategies, and techniques tailored to their service and role in the recovery process. We illustrate CT-R training at the provider level for key recovery agents: case managers became therapy extenders in CT-R, Certified Peer Specialists learned to apply the CT-R conceptualization and interventions to themselves and their participants, and clinicians learned a CT-R group therapy program that increases positive action and engagement in recovery. We will provide program evaluation data for each project.

S03-2.
IMPLEMENTATION OF RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R) IN A STATE PSYCHIATRIC HOSPITAL SYSTEM: THE KEY PERSONNEL APPROACH

Presenter: Aaron Brinen, Psy.D.

SUMMARY:
This presentation will outline the planning and implementation of a CT-R program across three state psychiatric hospitals. Doctoral-level psychologists were first trained in CT-R for inpatients with persistent schizophrenia that had been in the hospital at least 75% of the time over the previous three years. CT-R instructors promoted skills learning, gave feedback on session samples, and planned communication of interventions to milieu staff. Psychologists then served as key personnel to implement CT-R unit-wide so as to effectively utilize the skills of treatment providers from many disciplines (psychiatry, social work, expressive arts) in service of the patients' recovery. We will present program evaluation data and discuss obstacles identified and overcome.

S03-3.
IMPLEMENTATION OF RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R) IN A STATE BEHAVIORAL HEALTH SERVICE

Presenter: Paul Grant, Ph.D.

SUMMARY:
The Olmstead v. L.C. Supreme Court decision mandates community reintegration for individuals with persistent and serious mental illness. Successful reintegration into the community will rely on a coordinated continuity of care system across levels of service provision. We will describe a comprehensive coordinated implementation project that introduced CT-R across a state mental healthcare system. Clinicians and other service providers were trained in the theory, strategies and techniques of CT-R and provided with 6 months of consultation to guide the integration of this approach into their everyday practices. We will provide data on the number and nature of individuals trained, a model for delivering this kind of intensive training from a remote location, and anecdotal feedback on the ways in which systematic training across service levels resulted in a more efficient and effective continuity of care system.

S03-4.
INTRODUCTION TO RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R): THEORETICAL BASIS, BASIC RESEARCH FOUNDATION, AND OVERVIEW OF DISSEMINATION AND IMPLEMENTATION

Presenter: Aaron T. Beck, M.D.

SUMMARY:
We present the results of a translational research program

supporting the formulation that dysfunctional beliefs ("If I fail partly, it is bad as being a complete failure"; "I prefer leisure activities that do not involve other people") play a proximal role in the determination and maintenance of negative symptoms and poor functioning in schizophrenia. Using these research findings as a basis, we will then outline a therapeutic approach for poor functioning that emphasizes goal setting, breaking goals down, guiding to success, positive reinforcement, and generalization to beliefs and attitudes. We will next present an analogue study that experimentally supports this basic therapeutic process at the root of CT-R. Then we will detail the results of a clinical trial that demonstrates the efficacy of CT-R to promote recovery. We conclude with an overview of the dissemination and implementation of CT-R into community mental health settings.

FRIDAY OCTOBER 11, 2013

SYMPOSIUM 04

INNOVATIONS IN INTEGRATED ASSESSMENT, SERVICE MATCHING, AND RECOVERY PLANNING FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Chair: Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the clinical principles of integrated recovery oriented practice with individuals with co-occurring conditions that permit the development of appropriately matched integrated recovery plan; 2) Become familiar with the flexible array of services that can be provided for individuals with co-occurring disorders in an integrated continuum of care; 3) Demonstrate the ability to use the ASAM PPC 2R and LOCUS 2010 as a framework for assessment and person-centered recovery planning for an individual with co-occurring disorders; 4) Practice applying the principles presented, using a recovery oriented and integrated tool as a mechanism for organizing and structuring integrated recovery planning.

SUMMARY:
Individuals with co-occurring mental health and substance use disorders represent a population with poorer outcomes and higher costs in multiple domains, and often present in complex crisis situations with complex needs requiring accurate assessment to determine appropriate program and service matching in the context of developing an integrated person-centered recovery plan. Despite the frequency with which this type of clinical situation occurs in adult and child service settings, most systems do not have an organized and systematic approach to help clinicians with the process of integrated assessment and recovery planning throughout the continuum of care. This symposium explores the issue of integrated assessment and recovery planning for individuals with psychiatric and substance use disorders, identifies the clinical principles of successful multi-problem, multi-dimensional assessment and intervention within a recovery oriented framework of service delivery, and then illustrates structured approaches for application of those principles in real world systems to real world clients. These principles are then illustrated through a description of the most common and widely available tools for integrated assessment and recovery planning that are already available for general system use. First, Dr. David Mee-Lee will describe application of the American Society of Addiction Medicine Patient Placement Criteria – Second Edition Revised (ASAM PPC2R) (Dr. Mee-Lee is the lead developer of that document) to organizing person-centered and integrated program/service matching and recovery planning approaches for individuals with complex mental health and substance use needs. Second, the symposium will discuss the newest applications of the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2010) (presented by Dr. Wes Sowers, the lead developer of that document) to the process of integrated assessment, level of care and service matching, and recovery planning. Finally, Dr. Minkoff will describe an integrated recovery planning template that has been developed and disseminated in system wide projects for developing recovery oriented integrated services using the Comprehensive Continuous Integrated System of Care (CCISC) framework in over 30 states In order to demonstrate the application of these tools, participants will be provided with a complex case example, assisted to use the tools, as well as their own clinical judgment, to determine appropriate interventions in the context of integrated recovery planning for that case, and then participate in a discussion to explore the current state of the art and science of assessment and recovery planning for individuals with co-occurring disorders and the clinical challenges that emerge in addressing their needs.

S04-1.
USING ASAM CRITERIA'S MULTIDIMENSIONAL ASSESSMENT TO DEVELOP PERSON-CENTERED RECOVERY PLANS

Presenter: David Mee-Lee, M.D.

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

S04-2.
PRINCIPLES OF INTEGRATED ASSESSMENT AND RECOVERY PLANNING FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

Presenter: Kenneth Minkoff, M.D.

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

S04-3.
USING THE LOCUS M-POWER PLANNER TO FACILITATE PERSON CENTERED TREATMENT PLANNING

Presenter: Wesley E. Sowers, M.D.

SUMMARY:
As systems move toward transformation, the need to engage consumers and family members in the assessment and planning process has become increasingly recognized. The lack of methods by which to do so effectively and efficiently has been an obstacle to implementation of person centered care in practice. Another force shaping transformation efforts has been the logic of the integration of various elements influencing behavioral health. The interaction of these elements has not been captured well in most processes designed to guide service intensity decisions

and treatment planning. This section will briefly describe the service intensity decision tool LOCUS and its treatment planning companion, the M-POWER planner and demonstrate how the use of electronic medical records can actually enhance a collaborative, person centered planning process

SYMPOSIUM 05

POLICIES AND POLITICS: MORE POTENT THAN PILLS? ADDRESSING THE SOCIAL DETERMINANTS OF MENTAL HEALTH

Chairs: Michael T Compton, M.D., M.P.H., Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the concept of the social determinants of mental health; 2) List five social determinants of mental health; 3) Discuss three activities that community psychiatrists may engage in to improve mental health in their communities by addressing social determinants.

SUMMARY:
In the 19th century, Dr. Rudolph Virchow noted that "Medicine is a social science, and policy its instrument. The Physician has a responsibility to cure society's ills."

This presentation challenges public, community, and social psychiatrists to consider their responsibility in addressing policies and politics that are damaging to the mental health of our communities. This symposium will focus on the social determinants of mental health and mental illness; that is, those factors stemming from where we grow, live, work, learn, and age that impact our overall mental health and well-being, and those factors that contribute to mental illness. Although there has been much previous focus on social determinants of physical health, there has been surprisingly little emphasis on the social determinants of mental health. Although mental illnesses are often underpinned by genetic predisposition and gene-by-environment interactions, we will highlight the social determinants of such disorders which are likely malleable through social and policy interventions. Each presentation will conclude with a call to action that includes intervention recommendations from an individual, community, and policy level, and how individual psychiatrists can lead in this pursuit. At the end of the symposium, time will remain for a lively discussion of these crucial but commonly neglected topics, including potential solutions.

This symposium is of particular relevance to pubic, social, and community psychiatrists, as well as health services researchers. The presenters are members of the Prevention Committee of the Group for the Advancement of Psychiatry (GAP) and will draw from their current work in defining, classifying, and characterizing the social determinants of mental health. After a definition of mental health promotion and prevention of mental illnesses, this presentation will elucidate the concept of social determinants of mental health and mental illness. Emphasizing the connection to social justice, this symposium will consider six domains of social determinants, pertaining to adverse childhood experiences, school drop-out and educational inequities, food insecurity, individual-level and area-level poverty and income inequality, the built and natural environment, and poor access to health care.

S05-1.
FOOD INSECURITY AS A SOCIAL DETERMINANT OF MENTAL HEALTH

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

SUMMARY:
Dr. Compton will give an overview of the effects of hunger, food insecurity, poor dietary quality, and nutritional deficiencies on mental well-being. Food insecurity is a social determinant of both physical illnesses and poor mental health. Tested and effective policy interventions that support good nutrition across the lifespan, addressing this social determinant of mental health, will be articulated.

S05-2.
POOR ACCESS TO CARE AS A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Frederick J.P. Langheim, M.D., Ph.D.

SUMMARY:
Dr. Langheim will present on the effects of poor access to care, specifically addressing unequal distribution and access to healthcare, varying quality of healthcare, and inequality of the mental health care system compared to the general healthcare system. The potential preventive benefits of mental health integration into primary care will be discussed.

S05-3.
POVERTY AND INCOME INEQUALITY AS A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Marc W. Manseau, M.D., M.P.H.

SUMMARY:
Dr. Manseau will present on poverty as a macro-level risk factor for poor mental health and will address issues of individual-level and area-level poverty. Specific topics to be discussed will include the "poverty tax," income inequality, relative deprivation, the widening gap between the rich and poor in the United States, and unacceptable rates of child poverty in the United States. Relevant policy implications, including social protective systems and redistributive welfare systems will be discussed.

S05-4.
THE BUILT AND NATURAL ENVIRONMENT AS A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Christopher Oleskey, M.D., M.P.H.

SUMMARY:
Dr. Oleskey will discuss how quality of the built environment and the natural environment and how neighborhoods, urban environments, green spaces, exposures, access to drugs/firearms, etc, represent social determinants of mental health. Furthermore, the impact of public transportation systems and rural development and rural-to-urban migration will be discussed. Policy solutions and issues related to urban planning will be addressed.

S05-5.
SCHOOL DROP-OUT AND EDUCATIONAL INEQUITIES AS A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Rebecca A. Powers, M.D., M.P.H.

SUMMARY:
Dr. Powers will present on school drop-out and educational inequities, and how they influence mental health outcomes. Policy approaches, such as those that set educational expectations and seek to prevent school drop-out in the United States, will be reviewed.

S05-6.
ADVERSE EARLY LIFE EXPERIENCES AS A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Carol Koplan, M.D.

SUMMARY:
Dr. Koplan will present a review of the impact of early childhood experiences on mental health, highlighting the "Adverse Childhood Experience" (ACE) study, childhood trauma, and foster care and separation from parents. Recommended interventions will focus on early home visits, prevention of child abuse and domestic violence, treatment of perinatal maternal depression, importance of the two-generation approach, and increasing social inclusion and connectedness.

SYMPOSIUM 06

ADVANCES IN ADDICTION PSYCHOPHARMACOLOGY

Chair: Henry R. Kranzler, M.A., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the pharmacology of nicotine, alcohol, opioids, and cocaine and other stimulants; 2) Demonstrate knowledge of medications that are approved by the US Food and Drug Administration for the treatment of nicotine, alcohol, and opioid dependence; 3) Demonstrate knowledge of medications that are being developed to treat nicotine, alcohol, opioid and cocaine and other stimulants.

SUMMARY:
This symposium will review the pharmacology of four major classes of addictive substances: nicotine, alcohol, opioids, and cocaine and other stimulants. Drugs approved to treat each disorder will be discussed and medications being developed to treat these addictions will also be considered. Over the past two decades, approximately a dozen new medications or formulations have been approved by the U.S. Food and Drug Administration to treat alcohol, nicotine, or opioid dependence. Smoking cessation and opioid maintenance treatments have achieved the greatest success, as reflected in the large number of individuals treated with nicotine replacement, bupropion, and varenicline for smoking and methadone and buprenorphine for opioid dependence. These medications have improved treatment outcomes and reduced the costs associated with these disorders. However, these medications are effective for only a fraction of the treatment-seeking population. Although three new medications were approved to treat alcohol dependence (i.e., oral naltrexone, long-acting injectable naltrexone, and acamprosate), they have not been as widely prescribed as the prevalence of the disorder would seem to justify. Medications to treat other addictive disorders, including cocaine and other stimulant dependence, have not been shown consistently to be superior to placebo treatment. However, research has identified some promising candidates for the treatment of cocaine dependence, including the anticonvulsant topiramate, the analeptic modafanil, and immunologically-based treatments. In summary, there is a growing number of efficacious medications to treat addictive disorders. Further, greater understanding of the neuropharmacology and pharmacogenetics of addictive disorders promises to provide additional options and methods to target therapy for these highly prevalent, often serious, and costly disorders.

S06-1.
MEDICATIONS TO TREAT ALCOHOL DEPENDENCE

Presenter: Henry R. Kranzler, M.A., M.D.

SUMMARY:
This lecture will discuss the pharmacology of alcohol, considering effects on multiple neurotransmitter systems. It will also review medications approved for treatment of alcohol dependence and others showing efficacy but which are not being developed for that indication. Efforts to use parenteral dosing, oral dosing on a targeted or as-needed basis, and pharmacogenetics to enhance treatment response will also be considered.

S06-2.
NICOTINE ADDICTION MEDICATION DEVELOPMENT AND PHARMACOGENETICS

Presenter: Caryn Lerman, Ph.D.

SUMMARY:
This lecture will review the pharmacology and pharmacologic treatment of nicotine dependence. Treatments to be covered include nicotine replacement therapies, bupropion and varenicline. Paradigms for nicotine dependence medication development will be discussed as will evidence supporting a pharmacogenetic approach to nicotine dependence treatment. Together this evidence will provide a foundation for considering the future of nicotine dependence medications and treatment models.

S06-3.
MEDICATIONS TO TREAT COCAINE AND OTHER STIMULANT DEPENDENCE

Presenter: Kyle Kampman, M.D.

SUMMARY:
This lecture will review the pharmacology of cocaine and other stimulants and the pharmacological treatment of dependence on these drugs. Medications that have been tested to treat cocaine dependence include antidepressants, anticonvulsants, analeptics, and immunotherapy. Recent findings that support the utility of some of these approaches to treat cocaine dependence will be reviewed, together with a more modest literature on the treatment of dependence on other stimulants.

S06-4.
MEDICATIONS TO TREAT OPIOID DEPENDENCE

Presenter: Laura F McNicholas, M.D., Ph.D.

SUMMARY:
This presentation will discuss the pharmacotherapy of opioid dependence. Therapeutic use of methadone, buprenorphine/naloxone and naltrexone will be covered. The concomitant need for counseling/psychotherapy will be addressed. New and novel formulations of medication and emerging psychotherapies will also be discussed.

SYMPOSIUM 07

CRITICAL PERSPECTIVES ON PSYCHIATRY AND HOPEFUL NEW PATHS: CONTRIBUTIONS FROM EUROPE, AUSTRALIA, AND THE UNITED STATES

Chairs: Kenneth S. Thompson, M.D., Carl I. Cohen, M.D.

Discussants: Helena B. Hansen, M.D., Ph.D., Bradley Lewis, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the multiple ways psychiatry has come under renewed critique around the world and the ways psychiatrists might begin to rethink their work; 2) Appreciate the role that psychiatry plays in either sustaining or challenging the social structures of societies ; 3) Understand the paths forward toward a renewed, socially aware psychiatry

and the challenges to be faced getting there.

SUMMARY:
Globalization, geopolitical circumstances, technological advances, and demographic shifts have created an accelerating process of economic/social dislocations around the world. The strains of these disruptions-such as deindustrialization, the shift to a finance and service economy, high levels of unemployment, mass migrations, economic stagnation and rising income and asset inequality-- are generating extensive societal distress and conflict along with political pressure on social welfare and health programs. In the psychiatry, for the past three decades the prevailing paradigm has been biomedically oriented and nosologically focused. In tandem with the Westernization of much of the world, the prevailing psychiatric paradigm has become the dominant world perspective. Nevertheless, the relevance and utility of this paradigm have been called into question by the historical changes described above coupled with evidence that mental illness has been increasing and that pharmacological treatment modalities have modest effectiveness. Moreover, mainstream psychiatry has failed to seriously engage in discussions about what might be called "positive mental health" or how a society creates conditions for maximizing the mental well-being of individuals, families, and communities.

Historical transformations coupled with this crisis in the prevailing psychiatric paradigm have created an opportunity to develop a new paradigm. Thus, globalization, despite its pernicious effects, has also allowed for the greater dissemination of various cultural perspectives of mental well-being; social upheavals have produced democratic movements that call for greater human rights, liberties, and personal development; and that recessions have increased recognition of social context, economic inequality, and their consequences. Moreover, recent developments in the academy from around the world in anthropology, philosophy, social sciences, and cognitive psychology have much to contribute to a new psychiatric paradigm.

This symposium will be bring together an international panel of psychiatrists to address the following objectives: (1) To describe the global conditions and the limitations of current therapeutic approaches that have produced a crisis in the prevailing psychiatric paradigm ; (2) To appreciate the role that psychiatry plays in either sustaining or challenging the social and economic structures of societies; (3) To examine how psychiatry can draw upon novel elements from around the world as well as advances within a variety of academic fields to lay the groundwork for a new paradigm.

S07-1.
THE PATIENT AS PRIMARY MOVER IN MENTAL HEALTH SERVICES: OUR BEST HOPE FOR CHANGE?

Presenter: Inger-Kari Hagene Nerheim

SUMMARY:
Many of us have been improving year by year, with research, training programs, etc. Still, we have let life years' expectancy drop. Too many are dissatisfied. What are we doing to change this fact, fast? What happened, that brought us to a treatment and care that thinks it ok to coax and coach and coerce people into not doing what they themselves wish, and then afterwards make it a scientific discussion about compliance. Is this actually legitimate? Legal? It is a time for raising some new questions. What about autonomy? Dignity? We lose ours, in taking theirs. Examples about how energy for change is being built up right now will be presented. Something important is happening in the thousand acts, all over, in the service, between professionals and people with a need for help, where the recovery model is an integrated principle throughout a service. Treatment based on the patient's own choice, based on his/her context and values will give hope, enthusiasm, cooperation and energy.

S07-2.
THE VIEW FROM DOWN UNDER

Presenter: Alan Rosen, D.P.M., M.B.B.S.

SUMMARY:
What is the core of the debate regarding Global Mental Health? Can we make a stand for a more recovery-oriented, less alienating, less colonially, less bureaucratically less biomedically & less pharma dominated mental health provision in both developing and developed countries? Isn't it preferable to be part of the struggle to get it right, even if against considerable odds, rather than just walking away from the campaign for improving "global mental health" because of a range of concerns regarding the currently dominant paradigm ? Examples will be drawn from Australasian Urban, Remote and Indigenous and East Timorese mental health initiatives.

S07-3.
MENTAL HEALTH, SOCIAL JUSTICE AND COMMUNITY DEVELOPMENT: WORKING WITH DIVERSE COMMUNITIES IN AN ENGLISH CITY

Presenter: Philip Thomas, M.D.

SUMMARY:
Critical perspectives on psychiatric theories and practice have, amongst other things, drawn attention to the limitations of technological psychiatry in mental health care. At the same time recent work in epidemiology has drawn attention to the importance of income inequality on life expectancy, mental health and wellbeing, and social cohesiveness. A breakdown in social cohesiveness is also associated with social adversity, and there is strong empirical evidence that this is an important factor predictive of adult psychosis. A way forward is to be found by thinking about the impact of income inequality on wellbeing in terms of social justice. In this view psychiatrists can play a significant role to play in facilitating community processes that build social capital and mitigate social adversity, through community development. In this talk I will describe community development, its outcomes, and effectiveness in working with culturally diverse communities in inner-city Bradford.

S07-4.
NON-DIAGNOSTIC PRACTICE

Presenter: Sami Timimi

SUMMARY:
Diagnostic thinking has a powerful and pervasive impact on mental health services, structuring guidelines, research, administrative systems and care pathways. This talk will examine what is included and not included in the diagnosis driven 'evidence base', which has become prescriptive for practice, not only in mental health, but also more widely across social care and education. The evidence base that supports (or otherwise) the scientific validity and clinical utility of using a diagnostic framework will be critically evaluated. Ideas on how practice may develop in a direction that is more effective, humane, and more compatible with the scientific evidence will be explored including the Outcome Orientated Approaches to Mental Health Services (OO-AMHS) project.

S07-5.
CRITICAL PERSPECTIVES FROM FRANCE: THE PSYCHOSOCIAL EFFECTS OF GLOBALIZATION ON MENTAL HEALTH - TOWARDS AN ECOLOGY OF THE SOCIAL LINK

Presenter: Jean Furtos, M.D.

SUMMARY:
Each era is a subject to powerful processes which influences the way people live in society. Our era is marked by the psychosocial effects of the neoliberal globalization present around the world. It produces a continued state of precarité (social insecurity) which is characterized by an evolving uncertainty in social links. At first this is noticed by the poorest and the sickest people, but it is also present in the very heart of our own societies- witness the growing insecurity of the "middle class" at the center of the last American election. This uncertainty weakens the principles of life as well as the social support structures and produces a triple loss of confidence: in ourselves, in others, and in the future. It is definitely a challenge to take up. Yet there is some hope too, in the new world coming. Just as old social links are challenged, new ones can be formed, especially given the growing technological capacities for communication.

SYMPOSIUM 08

ADVANCES IN MEDICAL CARE OF PATIENTS WITH SERIOUS MENTAL ILLNESS (SMI)

Chair: Lydia Chwastiak, M.D., M.P.H.

Discussant: Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the critical need for interventions to improve medical outcomes among patients with serious mental illness, and the opportunity for community mental health centers to assume accountability for medical outcomes; 2) Learn models for assuming a larger role in the provision of medical care for their patients with SMI who receive care in psychiatric settings; 3) Learn strategies for implementing evidence-based practices for improving health and healthcare among patients with serious mental illness, including both primary and secondary disease prevention.

SUMMARY:
Persons with serious mental illness die an average of 8 years younger than the rest of the population, and the vast majority of these premature deaths are due to medical causes. Health disparities adversely affect individuals with serious mental illness, and they systematically experience greater obstacles to health and healthcare. There are higher prevalence rates of chronic conditions such as hypertension, obesity, diabetes, and HIV among persons with serious mental illness, and the presence of a psychiatric illness is associated with poorer quality of medical care for diabetes and other chronic conditions. These patients receive treatment from multiple providers in a variety of systems of care, and there is a critical need for coordination of care. These individuals are also disproportionately represented among other vulnerable groups, including chronically homeless and incarcerated individuals, adding another level of complexity to the management of their medical illness.

In this symposium, presenters will address recent advances in the medical care for the chronic medical conditions of obesity, diabetes HIV and Hepatitis C--and the critical gaps in the literature about the efficacy of these medical interventions for patients with serious mental illness. Challenges to providing high quality medical care and improving medical outcomes will be addressed, including improving communication, improving health behaviors and the self-management of chronic conditions, and strategies to navigate the increasingly complicated healthcare system. The panel will then discuss innovative approaches to improve medical care

among patients with serious mental illness.

S08-1.
APPROACHES TO THE MANAGEMENT OF SEVERE OBESITY IN PATIENTS WITH SMI

Presenter: Lydia Chwastiak, M.D., M.P.H.

SUMMARY:
Dr. Chwastiak will discuss the epidemic of obesity among persons with SMI, and the increased rates of class III (severe) obesity (BMI > 40 kg/ m2). She will review the literature on the effectiveness of pharmacologic and non-pharmacologic weight management interventions in this population, the clinical assessment of the appropriateness and risks and benefits of bariatric surgery.

S08-2.
BLOOD-BORNE INFECTIONS IN SMI: UPDATE ON HEPATITIS C AND HIV/AIDS

Presenter: Oliver Freudenreich, M.D.

SUMMARY:
Dr. Freudenreich will provide an overview of two blood-borne infections and their relevance for patients with SMI: hepatitis C, and HIV/AIDS. His talk will outline the role that psychiatrists can play in the screening for these diseases and in advocacy for treatment in often marginalized patients.

S08-3.
INTEGRATION OF MEDICAL CARE INTO COMMUNITY MENTAL HEALTH SETTINGS

Presenter: Lori E. Raney, M.D.

SUMMARY:
Dr. Raney will discuss approaches community psychiatrists can take in addressing chronic medical issues. She will describe clinical models that bring primary care into community mental health settings to address chronic medical illness in these settings.

S08-4.
PSYCHOSOCIAL TREATMENT APPROACHES TO OPTIMIZE ILLNESS SELF-MANAGEMENT AND RECOVERY FOR PATIENTS DIAGNOSED WITH SMI

Presenter: Corrine Cather, Ph.D.

SUMMARY:
Dr. Cather will describe psychosocial treatment interventions that have been developed to educate patients about chronic medical issues and to promote the patient taking an active role in the management of his or her own illness. Topics to be discussed will include: optimizing patient-provider communication, teaching patients how to self-monitor signs and symptoms, and promoting treatment adherence.

SYMPOSIUM 09

"BENDING" DIAGNOSTIC CRITERIA TO OBTAIN SOCIAL SERVICES FOR PATIENTS

Chairs: Donovan A. Wong, M.D., Joanna Fried, M.D.

Discussants: Timothy C. Harlan, J.D., Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize that "bending" diagnostic criteria is being used to obtain social services for patients; 2) Understand the reasons why some psychiatrists believe "bending" diagnostic criteria is appropriate and necessary to obtain social services for patients; 3) Understand the reasons why some psychiatrists believe "bending" diagnostic criteria is inappropriate to obtain social services for patients.

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

S09-1.
ARGUMENTS AGAINST "BENDING" DIAGNOSTIC CRITERIA TO OBTAIN SOCIAL SERVICES

Presenter: Donovan A. Wong, M.D.

SUMMARY:
This presenter will present a case to illustrate the complexities involved in "bending" diagnostic criteria to obtain social services for patients. He will also discuss the arguments against doing this and point out how this can overall be harmful for patients, society and the field of psychiatry.

S09-2.
DIAGNOSING DYSFUNCTION

Presenter: Joanna Fried, M.D.

SUMMARY:
Will present a case illustrating the difficulties involved in appropriately diagnosing homeless individuals with complicated presentations and obvious disabilities; will discuss issues which arise when a disabled individual's history/ symptomatology do not fit into the limited DSM diagnostic criteria considered to be "SMI" by certain agencies determining eligibility for benefits and entitlements.

S09-3.
CASE #: FUNCTIONAL IMPAIRMENT, DIAGNOSTIC UNCERTAINTY

Presenter: Sosunmolu O Shoyinka, M.D.

SUMMARY:
The presenter will discuss a case in which a legal suit for disability was brought against former employers by a previously high functioning individual with clear functional impairment despite diagnostic uncertainty.

SATURDAY, OCTOBER 12, 2013

SYMPOSIUM 10

CULTURALLY INFORMED COMMUNITY MENTAL HEALTH CARE OF IMMIGRANTS

Chair: Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand and utilize a conceptual model for addressing the mental health and cultural needs of immigrant and refugee populations in the US; 2) Recognize and understand the unique needs of five prevalent groups of immigrants in the United States; 3) Understand and implement simple cultural modifications to diagnostic and treatment approaches with immigrants and refugees and particularly with the five groups that will be discussed.

SUMMARY:
Objectives: The population of immigrants and refugees in the U.S. has grown at a rapid rate over the past 30 years. Today, we have over 50 million immigrants living in the US, with children born to immigrants comprising at least 20 percent of the population under 18. Their origins are quite diverse, and increasingly from non-Western nations, but they are united by the common challenge of navigating through and adapting to a culture that is initially foreign. At the same time, they face a number of unique stressors, including socioeconomic and educational challenges, language barriers, impact of immigration traumas, pressures to assimilate, identity conflicts, and stresses from discrimination and marginalization. An increasing literature points to high risks for emotional disturbance and mental illness and mental health morbidities in this population. However, our community mental health system is not well prepared to effectively address their needs. Methods: This symposium will first review an overall model for providing mental health services to immigrant populations, based on practice parameters for culturally competent care (in the process of being approved by the American Academy of Child and Adolescent Psychiatry), as well as unique characteristics, special needs, and indicated approaches to be used with immigrants from a diverse range of backgrounds. These include: India, Pakistan, Turkey, East Asians, and Caribbean Latinos. For each of these populations, we will include presentations on their significance in the U.S. population, mental health needs/ prevalent disorders, cultural beliefs regarding mental health (including stigma), acceptable service approaches, and effective treatment approaches. We will also discuss population-specific programs that have been found to be effective in addressing cultural and clinical needs. Conclusions: Failure by the United States to address these new mental health challenges could result in significantly higher mental health morbidity (and mortality) for decades to come.

S10-1.
MODEL FOR CULTURALLY-INFORMED COMMUNITY MENTAL HEALTH CARE AND CARIBBEAN LATINO IMMIGRANTS

Presenter: Andres J. Pumariega, M.D.

SUMMARY:
6 million Caribbean Latino immigrants live in the US, mostly of Puerto Rican, Dominican, and Cuban origin. Each nationality has distinct immigration history and stressors, but share common cultural heritages from indigenous, Spanish, and African roots. The prevalence of disorders in these populations ranges widely; Puerto Ricans have the highest prevalence rates and burden but other nationalities having significant needs. This presentation will first review a model of culturally informed care, based on the cultural competence and systems of care models and embodied in the draft AACAP practice parameters on culture. The needs and approaches to culturally-informed care of Caribbean Latino immigrants will be used as serve as an example, with discussion of cultural values affecting mental health care, culturally informed approaches to evaluation and community-based treatment. Evidence-based treatment approaches for Caribbean Latinos will also be addressed.

S10-2.
CULTURALLY-INFORMED CARE OF PAKISTANI IMMIGRANTS

Presenter: Shazia A. Savul, M.D.

SUMMARY:
Pakistan is the 12th highest ranked source country for immigration into the United States. The U.S. Census Bureau in 2010 estimated over one third of a million persons of Pakistani origin living in the United States. Actual numbers may even be higher. Immigrants generally have less access to, and lower utilization of, mental health services. Cultural stigma like keeping mental health concerns within the family and accepting psychiatric illness as God's will are additional barriers for this ethnic group. In certain high risk individuals, the migration process coupled with difficulties in acculturation, can lead to long-lasting psychological problems, including depression, anxiety, posttraumatic stress disorder, and a high risk for suicide. Comprehensive, coordinated, and ongoing mental health services for immigrant populations are needed. In addition, psychiatrists need to familiarize themselves with specific cultural needs of Pakistani immigrants.

S10-3.
CULTURALLY-INFORMED COMMUNITY CARE OF IMMIGRANTS IN USA: ASIAN INDIAN POPULATION

Presenter: Basant K Pradhan, M.D.

SUMMARY:
Asian Indian population was the 3rd largest subset and one of the fastest growing ethnic groups in the United States (2010 Census). Studies show that Asian Americans have lower rates of mental illness than whites but seek treatment less often.

Asian-Indians interpret wellness in the context of "wholeness" which is very different from the western approach to health. In Asian Indian populations, stigma about mental illness is significant, they believe that emotional problems reflect life circumstances or can be caused by supernatural forces, and mental health can be achieved through willpower. All these often lead to seeking mental health treatment relatively late and tendency to drop out early. Also help seeking patterns in treatment of mental illness in India vary significantly from those of Europeans and Americans. Now consensus is emerging that culturally informed therapeutic approach is essential to effectively handle mental health issues in this population.

S10-4.
CULTURALLY-INFORMED CARE OF TURKISH IMMIGRANTS AND THEIR FAMILIES

Presenter: Hatice Burakgazi-Yilmaz, M.D.

About 300,000 Turkish citizens living in the US, increasing since the 1980s due to closer relations with the U.S. and high economic growth rates in Turkey, while the population of Turkish descent surpasses one million. The majority of Turkish population lives in East Coast, mainly New Jersey, New York, and Northern Virginia. Turkish people are a heterogeneous group, coming from various religious and cultural backgrounds and socioeconomic levels. After 9/11, they have been the target of xenophobic attitudes and behaviors, increasing their risk of adjustment disorders, depression, and anxiety. Turkish views of psychiatric disorders, especially posttraumatic stress disorder (PTSD), depression, and anxiety changed after a major devastating earthquake in Turkey in 1999, with greater overall awareness and less stigma. This presentation will review the above issues in depth as well as discuss culturally acceptable approaches to diagnostic evaluation and treatment.

S10-5.
CULTURALLY-INFORMED COMMUNITY CARE OF EAST ASIAN IMMIGRANTS

Presenter: Zheya J. Yu, M.D., Ph.D.

SUMMARY:
Asians comprise the fastest growing subset of the U.S. population, with a growth rate (46%) more than four times that of the total population between 2000 and 2010. The Chinese population was the largest Asian group, followed by Filipinos and Asian Indians. The overall prevalence of psychiatric disorders in East Asians does not significantly differ from those for other Americans, although the distribution of specific disorders may be different. For example, East Asians may have a higher rate of neurasthenia, and PTSD is more prevalent among Southeast Asian refugees. Asian Americans in general have the lowest rates of utilization of mental health services among ethnic populations. For those who do seek treatment, the severity of disturbance is usually high. This presentation will discuss patterns of prevalence, cultural factors impacting perceptions and expressions of mental illness, and culturally informed approaches to diagnostic evaluation and reduction of barriers (including stigma).

SYMPOSIUM 11

WHAT IS THE ROLE FOR PSYCHIATRISTS IN THE TRANSFORMED HEALTHCARE SYSTEM?
Presidential Symposium

Chair: Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session the participant should be able to: 1) Describe the overall design of the two DSM5 Field Trials and their objectives in the DSM5 revision process, 2) Explain the various outcomes assessed in the field trials, including that of diagnostic criteria and dimensional assessments, 3) Provide examples of specific findings from the field trials, 4) Discuss the potential ways in which findings from the field trials may impact the future of clinical care using DSM5.

SUMMARY:
Field trial testing of proposed revisions to DSM5 represent an important and informative method of empirically assessing the reliability, clinical utility, and feasability of the draft diagnostic criteria and dimensional assessments. Field trials have been conducted in two general areas: first, amongst largescale, medical and academic settings and second among solo and small practice, routine clinical care settings. Both field trial designs offer the opportunity to collect valuable information on how proposed changes may impact patient care and realworld aspects of psychaitric clinical service, including obtaining patient reported outcomes, effectively engaging in treatment planning, and successfully monitoring course of illness. This session will orient audiences to the overall design and purpose of the DSM5 Field Trials as well as discussing, where available, select results from both the large scale field tests as well as the routine clinical practice trials. Select outcomes related to the diagnostic criteria themselves as well as those pertaining to proposed dimensional aspects of psychiatric diagnosis will be discussed.

S11-1.
DSM5 FIELD TRIALS: NEW METHODS, NEW INSIGHTS

Presenter: Helena C. Kraemer, Ph.D.

SUMMARY:
The basic design of DSM5 field trials will be reviewed, with emphasis on how and why they differ from previous DSM field trials. Then the impact of the experience and results on the design and execution of future diagnostic field trials will be considered, with emphasis on field trials that may be relevant to DSM5 as a "living document".

S11-2.
DSM5 FIELD TRIALS IN ACADEMIC OR LARGE CLINICAL SETTINGS: DETAILED FINDINGS FOR SCHIZOPHRENIA, DEPRESSION, AND ADHD

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

SUMMARY:
In 2010, the APA initiated testing of proposed changes to DSM5 across 11 medical and academic centers. Over the course of the following 12 months, these institutions gathered data on the reliability, feasibility, and clinical utility of draft diagnostic criteria and other proposed changes to DSM5. Their findings played a significant role in informing decisions by the 13 DSM5 Work Groups, and the novel, innovative method of data collection used in the DSM5 Field Trials represents advancement beyond the field testing strategies utilized during previous revisions of the manual. This presentation will share with audience members detailed findings from the field tests with particular emphasis on results gathered from tests of the diagnostic criteria for Schizophrenia, Major Depressive Disorder, and Attention-Deficit/Hyperactivity Disorder. Discussion will include: descriptions of the proposed revisions and how they differ from current criteria in DSMIV; the rationale of the proposed changes; descriptions of the populations and settings in which tests of these specific disorders were conducted; statistical results from the field trials; and potential implications of adopting these specific disorder changes, clinically as well as in other relevant contexts (e.g., research, insurance coverage, etc.).

S11-3.
DSM5 FIELD TRIALS IN ACADEMIC OR LARGE CLINICAL SETTINGS: SUMMARY AND IMPLICATIONS

Presenter: Diana E. Clarke, Ph.D., M.Sc.

SUMMARY:
DSM5 academic field trials were conducted in eleven academic or large clinical settings in the United States and Canada including seven adult and four pediatric sites. This group of academic trials represented an opportunity to examine, indepth, select revisions to a number of psychiatric disorders likely to be of high public health significance (e.g., Mood Disorders, Psychotic Disorders, Substance Use Disorders, etc.) among a range of clinical populations (adult, pediatric, adolescent, geriatric) and settings (general psychiatry and specialty clinics). This presentation will lay the groundwork for later discussion of detailed findings from field testing by giving audiences an overview of the design and implementation strategy used by DSM5 leadership in conducting these tests. In addition, this session will provide a synopsis of pertinent findings from these field trials, including data on the reliability of the proposed diagnostic revisions as well as the clinical utility and feasibility of the draft changes.

S11-4.
DIMENSIONAL MEASURES IN PSYCHIATRIC DIAGNOSIS: RESULTS FROM THE DSM5 FIELD TRIALS

Presenter: William E. Narrow, M.D., M.P.H.

SUMMARY:
The addition of dimensional measures to DSM5 represents one of the manual's most significant departures from the current diagnostic system. Dimensional assessments were proposed as a method to address some of DSMIV's known shortcomings, including the representation of psychiatric

disorders as entities that fall neatly into discrete categories. Although commonly used in clinical research, dimensional approaches are not standard in psychiatric patient care. Developers of DSM5 are hopeful that the proposed integration of dimensional assessments with categorical diagnoses may help address this gap between science and practice. This presentation will describe findings from the DSM5 field trials of proposed crosscutting and diagnosisspecific severity measures, with specific attention given to results from the trials of Schizophrenia, Major Depressive Disorder, and AttentionDeficit/Hyperactivity Disorder. Topics will include a brief overview and rationale of dimensional strategies that were tested, and results from the 11 academic field trial sites, including testretest reliability, clinical utility, and feasibility of the proposed measures. Clinical implications of integrating dimensional and categorical approaches to diagnosis in DSM5 will be discussed.

S11-5.
TESTING DSM5 IN ROUTINE CLINICAL PRACTICE SETTINGS: TRIALS, TRIBULATIONS, AND TRIUMPHS

Presenter: Eve K. Moscicki , Sc.D., M.P.H.

SUMMARY:
The DSM5 Field Trials in Routine Clinical Practice Settings (RCP) examined the feasibility, clinical utility, and sensitivity to change of the proposed DSM5 diagnostic criteria and dimensional assessment measures as used by individual clinicians in routine clinical practice settings, representing the first time in the history of the DSM that the proposed diagnostic criteria were tested outside of academic settings. In another first, disciplines outside of psychiatry were invited to participate. This presentation will provide an overview of the design, sampling, procedures, and major findings for this important component of the DSM5 Field Trials. Study participants included two samples of clinicians. The first was a representative sample of over 1,200 randomly selected general, child and adolescent, geriatric, addiction, and consultationliaison psychiatrists. The second sample included nearly 4,000 clinicians from six disciplines who volunteered to participate in the field trials. Volunteers included psychiatrists, advanced practice psychiatricmental health nurses, clinical psychologists, clinical social workers, licensed counselors, and marriage and family therapists. All participating clinicians had to meet strict eligibility criteria in order to participate. Eligible clinicians completed webbased DSM5 training, including practice with the REDCap electronic data capture system, and enrolled at least one new and one existing patient into the field trial. Data characterizing the representative and volunteer samples of clinicians will be presented, including clinical discipline, specialty, caseload, nature of practice, practice setting, and patient caseload characteristics. The presentation will include a summary of major findings and a brief discussion of the unique challenges, opportunities, and successes found in implementing a largescale scientific endeavor in smallscale settings.

SYMPOSIUM 12

ESSENTIALS OF PSYCHIATRIC EMERGENCY CARE FOR CHILDREN AND ADOLESCENTS

Chair: John S. Rozel, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand some of the broad trends and epidemiology of children in the psychiatric emergency department and common presentations and diagnoses in the Psychiatric Emergency Service; 2) Learn relevant national legal standards for the evaluation and care of children in mental health settings and how to identify standards specific to their state ; 3) (Learn?) different approaches to the interview, history and mental status examination to be used for children, adolescents and their families; 4) Learn basic physiologic differences between youth and adults and how that impacts medical clearance and pharmacotherapy decisions; 5) Understand what factors favor a specialized evaluation or consultation of a child psychiatrist and how to proceed when such resources are unavailable.

SUMMARY:
Children and adolescents are presenting more frequently with psychiatric emergencies and few regions have dedicated child and adolescent psychiatric emergency services. While some facilities employ child and adolescent psychiatrists or even have dedicated space or teams for caring for youth with psychiatric emergencies, most facilities do not. Combining the perspectives of physicians from General Psychiatry, Emergency Medicine, and Child and Adolescent Psychiatry backgrounds, basic guidance for non-specialists will be offered. Specifically, guidance for Emergency Medicine and General Psychiatry physicians without child training and guidance for Child & Adolescent Psychiatrists without emergency training will be offered. Several specific domains where child and adolescent issues, symptoms, or interventions are significantly different from adults will be highlighted:

Legal issues. Legal standards for consent and confidentiality for mental health and addiction treatment for minors, definitions of child abuse, and mature minor or emancipation standards differ significantly between states. Standards for Pennsylvania will be used as an example and attendees will be directed to convenient resources for their own states.

Trauma issues. Trauma exposure is endemic in child acute psychiatric settings and trauma informed care should be considered a universal precaution. PTSD symptoms can manifest differently than in adults and can mimic many other disorders. Special strategies for the clinical management of children with a trauma history will be discussed.

Interviewing strategies, history and mental status exam. Children, adolescents and their families often require different approaches to the clinical interview and careful attention to the selective use of guiding or leading questions. Elements of atypical adult history may be moot for a child (e.g., military history), require modification (e.g., assess parents' employment, not the child's), or require additional exploration (e.g., a much more detailed school academic and disciplinary history). Some symptoms or signs are more readily elicited from children than from parents (e.g., children with depression will endorse feeling hopeless, sad, or unloved while parents notice social withdrawal and irritability).

Medical clearance. Like adults, a general history and physical examination are essential; similarly, "routine" labs or imaging studies are not appropriate. Discussion of which lab tests or imaging studies may be indicated and when will be discussed as well as counterarguments to pervasive but clinically contraindicated requests (e.g., neuroimaging) will be offered.

Medications for agitation. There are no medications FDA approved for use for acute agitation in children or adolescents. Considerations of pharmacokinetic and pharmacodynamic differences of children can guide use of off-label treatment in children including selecting agents, routes, and timing of medications.

S12-1.
EPIDEMIOLOGY AND TRENDS IN CHILD AND ADOLESCENT EMERGENCY PSYCHIATRY

Presenter: Jagoda Pasic, M.D., Ph.D.

SUMMARY:
Available research suggests an increased frequency of emergency presentations for children and adolescents. As with adults, demand for mental health services often outstrips available resources. Inpatient units and partial programs are often full or far away and the wait to see an outpatient child psychiatrist can be months. Trends in emergency presentations of children and adolescents including issues of diagnosis, presenting complaints and linkage to services will be discussed to frame the rest of the discussion.

A clinical approach to one of the most common presentations -- disruptive behavior -- will be discussed. Considerations of differential diagnosis and rational selection of PRN agents will be reviewed.

S12-2.
TRAUMA-INFORMED CARE IN CHILDREN AND ADOLESCENTS

Presenter: John S. Rozel, M.D.

SUMMARY:
Trauma and PTSD related symptoms are common in youth involved in mental health services. Trauma history and PTSD symptoms can be one of the strongest predictors of heavy utilization of emergency psychiatric services. The frequency of trauma in high acuity settings (e.g., emergency departments, inpatient units, residential treatment, and juvenile justice) requires that trauma informed care be considered a universal precaution. Trauma informed care with children should influence nearly every aspect of their care: from how they are greeted, interviewed, physically examined, deescalated, and restrained. Forms of trauma discussed include both commonly recognized forms such as neglect and abuse by parents as well is institutional abuse or trauma from restraints and holds. Further, because of the neurotrophic effects of acute and chronic stress associated neurotransmitters on the developing brain, trauma symptoms can manifest in a multitude of ways and be highly resistant to treatment.

S12-3.
MEDICAL EVALUATION OF CHILDREN AND ADOLESCENTS WITH PSYCHIATRIC SYMPTOMS

Presenter: Leslie Zun, M.B.A., M.D.

SUMMARY:
Like adults, a general history and physical examination are essential; similarly, "routine" or "screening" labs or imaging studies are not appropriate. At best they are unnecessary and costly, at worst they can be harmful. A careful history and physical examination is the essential first step and will guide providers to order tests as specifically indicated. Laboratory and imaging studies are best used to answer specific clinical questions (e.g., is this Wilson's disease?) or for therapeutic drug monitoring. Specialized evaluation by consulting services (e.g., pediatric neurology) is generally significantly more useful than indiscriminate ordering of neuroimaging or EEGs.

S12-4.
INTERVIEWING STRATEGIES, HISTORY TAKING AND THE MENTAL STATUS EXAMINATION

Presenter: Garrett M. Sparks, M.D., M.S.

SUMMARY:
Children, adolescents and their families often require different approaches to the clinical interview and careful attention to the selective use of guiding or leading questions. Elements of a typical adult history may be moot for a child

(e.g., military history), require modification (e.g., assessing parents' employment, not the child's), or require additional exploration (e.g., a much more detailed school academic and disciplinary history). Some symptoms or signs are more readily elicited from children than from parents (e.g., children with depression will endorse feeling hopeless, sad, or unloved while parents notice social withdrawal and irritability). Certain mental status findings that are abnormal in an adult may be normal in a child and vice versa. Specific strategies for working with cooperative and resistant children and families will be discussed.

S12-5.
CLINICAL DECISION MAKING AND DISPOSITION WITH CHILDREN AND ADOLESCENTS

Presenter: Seth M. Powsner, M.D.

SUMMARY:
Clinical decision making with children and adolescents in the emergency setting can be extremely complex. Some cases clearly require admission; some can safely return to their home and community services. Guidance on which cases should be admitted, who can safely go home and strategies for managing those whose needs are less clear will be provided. Additionally, which types of cases most clearly require the input of a child psychiatrist and how to proceed when no such specialist is available will be discussed.

SYMPOSIUM 13

THE USE OF OUTCOME MEASUREMENT TO IMPROVE TREATMENT AND CARE

Chair: Victor Buwalda, M.D.

Discussant: Lloyd I. Sederer, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Outcome measurements these days are more and more common. This symposium gives an insight in the challenges and possibilities of outcome measurements and related topics, concerning psychiatry and psychotherapy. 2) Learn about the different possibilities of this model and the embedding in daily practice. 3) Get an overview of the differences in the VS, UK and the Netherlands.

SUMMARY:
Outcome measurement (OM) has expanded in the past years (inter)nationally. Government and insurance companies support the implementation and the use of outcome measures, as performance indicators and to be able to compare the results of mental health organizations. The negative effect of this (inter)national wide and top down implementation is that clinicians are less eager to adopt this support tool as part of their clinical care process. They experience the interest of these external parties as a threat for their autonomy as professional. There are several opportunities to get the clinicians back in the lead again and use OM as a tool to support the enhancement of quality of the clinical care process. In this symposium the several ways of using OM in the clinical care process are addressed. First, the challenges of implementing the system into the clinical care process are discussed. An operation management tool is made visible. Also the attitude of patients towards this working method will be discussed. If patients are not willing to participate in filling in questionnaires during treatment, their feedback on treatment progress is missing and the effectiveness of OM is less. Second an outcome monitoring feedback model is presented based on Lamberts feedback algorithm used in the Netherlands and the way the clinicians' attitude plays a role. Thirdly the use of both outcomes and process measures in a client-centered psychotherapy clinic, developed in Leuven Belgium, is demonstrated. The presenters will show the individual use of questionnaires to support their individual therapies. Fourthly the results of analyses of progress and outcome of patient groups like geriatric patients and patients with severe mental Illnesses, are presented, which may help professionals to have more realistic expectations with regard to the progress of their patients. The symposium will end with an overview of use of OM in de different countries (the US, UK and the Netherlands). Also the added value of the different systems in these countries is discussed. Altogether the symposium gives the participants an overview of the different possibilities of use of OM and the pitfalls.

S13-1.
KNOWLEDGE OF OPERATIONS MANAGEMENT AND THE ATTITUDE OF PATIENTS CAN MAKE THE DIFFERENCE

Presenter: Victor Buwalda, M.D.

SUMMARY:
Implementing a new system into the clinical care process is not an easy task to do. In this context it is important to know what the patients' attitude is because outcome measurement directly affects their treatment. In this presentation implementation of outcome measurement is made visible with a case history in a large mental health institute. Operations management can help overcome the challenges during implementation and a tool in this field can make the effects visible and acceptable. Also the attitude of patients towards outcome measurement will be discussed. If patients are not willing to participate in filling in questionnaires during their treatment the effectiveness of outcome measurement is less. A solid foundation starts with knowledge of their attitudes and the factors that play a role in the implementation. In this presentation a study will be presented on the attitude of patients concerning outcome measurement.

S13-2.
PATIENT-REPORTED OUTCOMES IN INTERNATIONAL PERSPECTIVE: THEIR USES IN THE UNITED STATES, THE UNITED KINGDOM, AND THE NETHERLANDS

Presenter: Philip Van der Wees, Ph.D.

SUMMARY:
Patient-reported outcomes (PRO) are considered important for managing clinical quality. Several examples, especially in mental healthcare, exist of the routine collection of PRO within healthcare organizations and at health system level. However, the use of PRO in clinical practice and performance measurement are still in the early stages of development. We assessed the feasibility for the uses of PRO in three settings: United States, United Kingdom, and the Netherlands. We identified barriers and facilitators and consequently built a model to support organizations in using PRO in clinical practice and performance measurement. The results showed considerable variation in the uses of PRO in both top-down and bottom-up approaches. Key factor for the further implementation of PRO is the establishment of the meaningful use of PRO at clinical, organizational and health system level within an integrated system of data collection, analysis and reporting.

S13-3.
THE ROLE OF THE CLINICIAN IN OUTCOME MONITORING

Presenter: Kim de De Jong, Ph.D.

SUMMARY:
Providing outcome monitoring feedback to therapists seems to be a promising approach to improve outcomes in clinical practice. However, it will only improve outcomes if clinicians actively use the feedback on their patients' progress. Patients (n=413) were randomly assigned to either a feedback or a no-feedback control condition. There was no significant effect of feedback in the full sample, but feedback was effective for not-on-track cases for clinicians who actively used the feedback. Internal feedback propensity, self-efficacy, and commitment to use the feedback moderated the effects of feedback. Use of feedback was predicted by the clinician's commitment to use the feedback and sex of the clinician. Results demonstrate that feedback is not effective under all circumstances and clinician factors are important when implementing feedback in clinical practice.

S13-4.
THE ROLE OF THE CLINICIAN IN OUTCOME MONITORING

Presenter: Kim de Jong, Ph.D.

SUMMARY:
Providing outcome monitoring feedback to therapists seems to be a promising approach to improve outcomes in clinical practice. However, it will only improve outcomes if clinicians actively use the feedback on their patients' progress. Patients (n=413) were randomly assigned to either a feedback or a no-feedback control condition. There was no significant effect of feedback in the full sample, but feedback was effective for not-on-track cases for clinicians who actively used the feedback. Internal feedback propensity, self-efficacy, and commitment to use the feedback moderated the effects of feedback. Use of feedback was predicted by the clinician's commitment to use the feedback and sex of the clinician. Results demonstrate that feedback is not effective under all circumstances and clinician factors are important when implementing feedback in clinical practice.

S13-5.
MONITORING AS AN ALLIANCE IMPROVING METHOD

Presenter: Dave Smits

SUMMARY:
Clinicians differ in their effectiveness to affect change. Research shows that feedback generated by process and outcome monitoring instruments has great potential to increase therapeutic efficiency and efficacy. Many available monitoring systems focus on quantifying therapy outcomes, thereby missing the potential to gain insight on how therapy works, or, more important, on how therapy fails to work. At the KU Leuven (Belgium), a multi-dimensional, multimodal monitoring system (QIT online) is developed. It supplies clinicians with rich, idiosyncratic data about ongoing therapeutic processes. Recent process research indicates that monitoring influences the quality of the therapeutic relation, an important predictor of treatment success. In this presentation we will focus on how feedback from a monitoring system supports clinicians interventions in a clinically relevant fashion. We will also show how it can be used to identify, prevent or repair alliance ruptures or strains.

S13-6.
RATE OF CHANGE OF VARIOUS PATIENT GROUPS TO HELP INTERPRET INDIVIDUAL PROGRESS

Presenter: M. Annet Nugter, Ph.D.

SUMMARY:
Routine Outcome Measurement generates large databases with outcomes of various patient groups. First analyses of these data show that there are huge differences in outcomes and rate of change between patient groups. In this presentation data on rate of change and outcome will be presented of three groups of patients:

• 1550 adult patients with anxiety and depressive disorders who receive short term treatment

• 2500 patients with Severe Mental illness (SMI), predominantly schizophrenia and other psychotic disorder who receive long term Flexible Assertive Community Treatment (FACT) and

• 1300 elderly patients with various disorders, in several treatment settings.

Sophisticated statistical analyses are applied to discover different progress figures between and within these groups and factors that may predict improvement or lack of it. These figures may help clinicians to use and interpret the feedback on the progress of their individual clients.

SYMPOSIUM 14

"HOT SPOTTING": PROACTIVE PSYCHIATRIC INTERVENTION IN HIGH UTILIZERS OF HEALTHCARE

Chair: Paul Desan, M.D., Ph.D.

Discussant: Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the nature and incidence of behavioral factors which may underlie the "hot spotter" patient, the high utilizer of medical care; 2) Understand how integrated medical and psychiatric treatment, including proactive screening and outreach interventions, can improve the care of high utilizers, in the medical hospital and clinic; 3) Understand how new modes of organization of the healthcare system, including financial, administrative and technical changes, can promote rather than hinder integrated behavioral healthcare.

SUMMARY:
The traditional model of psychiatric consultation for the medically ill is failing us. In both medical inpatient and outpatient settings, the model requires specific referral to a psychiatrist, who is likely not an integral part of the medical team. When exacerbation of illness results in hospital admission, psychiatric care is again divided from medical care and from outpatient mental health care. Clearly the traditional model is not providing best care and is wasteful in its use of resources. New models are emerging of the integration across inpatient and outpatient domains and across medical and psychiatric domains. These new models are the focus of this symposium.

Paul Desan, MD, PhD will review past research on different models of hospital consultation services, and new research on more proactive models of consultation at Yale New Haven Hospital. These models identify more effectively and more promptly patients requiring psychiatric services. William Sledge, MD, will discuss implementation of a full scale multidisciplinary and proactive consultation service on inpatient medical units at that hospital. The new approach involves social workers and other professionals alongside psychiatrists, to provide close follow up of patients with behavioral issues, and prompt development of an integrated plan for care after discharge. Anita Everett, MD, will describe a new organization of the outpatient clinic system at Johns Hopkins University, which attempts to integrate behavioral care from hospital to clinic in an enveloping way. Roger Kathol, MD, will discuss evidence that better integration of care reduces net cost, and review how new forms of reimbursement, such as systems of accountable care or medical homes, will permit new modes of healthcare organization. Lori Raney, MD, will provide an overall view and moderate discussion from the audience.

The medical system is entering a phase of rapid change, and the practice of psychiatry must necessarily change: this symposium hopes to provide a vision of medical and psychiatric care integrated across inpatient and outpatient settings.

S14-1.
PROACTIVE MODELS OF PSYCHIATRIC INTERVENTION IN THE MEDICAL HOSPITAL

Presenter: Paul Desan, M.D., Ph.D.

SUMMARY:
The speaker will review evidence demonstrating that increased psychiatric consultation in medical hospitals can improve health outcomes, and reduce length of stay: research in both psychiatric and geriatric contexts suggests that proactive consultation methods are essential. He will discuss a project at Yale New Haven Hospital using psychiatrists embedded in medical teams: screening of all admissions identified patients who could benefit from consultation more effectively than standard care. The method enabled psychiatric services to be initiated earlier in admission and resulted in improved length of stay. He will also discuss a second project using a multidisciplinary approach to screening and intervention, which also resulted in improved outcomes and net cost savings.

S14-2.
IMPLEMENTATION OF A LARGE-SCALE MULTIDISCIPLINARY PROACTIVE INPATIENT CONSULTATION PROCESS

Presenter: William H. Sledge, M.D.

SUMMARY:
The speaker will describe initiation of a multidisciplinary screening and intervention process on multiple medical units at Yale New Haven Hospital. He will discuss experience in the development of efficient screening methodology, determination of staffing needs and training, and integration of different disciplines with different work strategies into a smoothly functioning team. He will present data on the types and incidence of behavioral problems treated, and on improvements in health outcomes and finances.

S14-3.
INTERVENING WITH HIGH-UTILIZING PATIENTS IN THE PRIMARY CARE SETTING

Presenter: Anita Everett, M.D.

SUMMARY:
The speaker will describe implementation of integrated behavioral health care in a university clinic system for a high cost group of individuals. She will describe the range of problematic health behaviors, and how such issues can be addressed in outpatient settings, including the use of ultra brief and CBT-oriented sessions that address psychiatric conditions, health behaviors and substance abuse. She will provide practical suggestions for psychiatrists taking on the role of supervising such care in the primary care setting.

S14-4.
THE PATIENT-CENTERED CARE MODEL: A NEW ORGANIZAION FOR INTEGRATED HEALTHCARE

Presenter: Roger G. Kathol, M.D.

SUMMARY:
The speaker will discuss the patient-centered model of care. He will summarize evidence that accountable care organizations, patient-centered medical homes, and guided care programs have shown cost reduction through reduced admissions, increased quality, and high satisfaction rates. New reimbursement systems will change pressures which impeded integration of behavioral health care. Success with patient-centered care will depend on more direct physician involvement, closer team function, and better communication channels among team members, the patient, and his family: new technical resources may play a key role and further improve the patient experience. A streamlined workflow and cost reduction will call for real-time monitoring of both clinical data and business process data.

SYMPOSIUM 15

ADVANCES IN BEHAVIORAL HEALTH INTERVENTIONS FOR COMBAT-RELATED INJURIES IN THE U.S. MILITARY

Chairs: Scott C. Moran, M.D., Brett J. Schneider, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the unique pattern of substance abuse in military populations including iatrogenic addictions in pain patients; 2) Assess novel treatment approaches used by military healthcare providers to anticipate and mitigate behavioral disturbances caused by brain injury; 3) Describe the role of TMS in military psychiatry and discuss unique uses of TMS in the military; 4) Differentiate military psychiatric residency training from civilian training and apply differences in their own setting.

SUMMARY:
The US Military has been at war for a decade. Repeated deployments and the nature of the battlefield have presented significant challenges to the mental health of our service members. Large numbers of service members have developed Post Traumatic Stress Disorder, Major Depression, Brain Injury, Addictions, and other sequelae of combat. Military suicide rates are at a high.

The symposium will review advances in treatment strategies for the behavioral health complications of combat, focusing on advances in our understanding of addictions in military populations, approaches to behavioral disturbances caused by brain injury, the use of Transcranial Magnetic Stimulation (TMS) in combat wounded, and the challenges in our education of the next generation of military behavioral health providers. At the end of the presentations the Chairman will lead a discussion with the audience on these issues.

S15-1.
BEHAVIORAL COMPLICATIONS OF COMBAT TBI

Presenter: David Williamson, M.D.

SUMMARY:
Dr Williamson will describe novel treatment approaches used by military healthcare providers to anticipate and mitigate behavioral disturbances caused by brain injury. The presentation will review the major themes emerging from review of the first 250 patients admitted to a new inpatient TBI Unit, staffed by a hybrid Neurobehavioral/TBI Rehabilitation Team. Significant findings include the prevalence of iatrogenic complications of aggressive analgesic polypharmacy and the utility of drug holidays as a diagnostic tool, the importance of family education and competence in favorable behavioral outcomes, the importance of multidisciplinary collaboration in effective management of severe TBI, the utility of comprehensive clinical review of neurobehavioral complications remote from injury, and the need for modified addictions treatment strategies in patients with severe TBI.

S15-2.
EMERGING DRUGS OF ABUSE IN THE US MILITARY

Presenter: Jonathan Wolf, M.D.

SUMMARY:
Active duty military members demonstrate different patterns of drug abuse than civilian drug abusers, in part due to frequent drug testing and a zero tolerance policy in the military, which bias drug users towards agents that evade standard drug testing. We will present data on different frequencies of drug use in civilian and military populations. Drugs overrepresented in the military such as inhalants and dextromethorphan will be discussed, as well as emerging drugs of abuse including synthetic cannabanoids "Spice," and substituted cathinones, "Bath salts." Presentation will cover detection, evaluation and treatment of substance use and will include a small case series of patients with atypically prolonged psychotic symptoms following synthetic cannabanoid use.

S15-3.
TRANSCRANIAL MAGNETIC STIMULATION IN THE MILITARY SETTING

Presenter: Geoffrey G. Grammer, M.D.

SUMMARY:
Transcranial Magnetic Stimulation (TMS) is a device currently FDA approved for the treatment of Depression that may have utility in the military setting. Active duty service members can have several sequelae of combat exposure, including psychological symptoms and physical trauma. TMS can affect changes in cerebral activity that can play a role in emotional states and may offer a non-pharmacologic method of treating pain conditions. Clinical applications for Major Depression, Post Traumatic Stress Disorder (PTSD), and combat trauma related extremity pain will be discussed. Ongoing research initiatives for suicidal ideation, mild Traumatic Brain Injury, and PTSD at Walter Reed National Military Medical Center will be reviewed with emphasis on scientific rationale and progress to date with considerations unique to the warfighter.

S15-4.
UNDERSTANDING MILITARY-SPECIFIC TRAINING FOR PSYCHIATRIC RESIDENCIES

Presenter: Scott C. Moran, M.D.

SUMMARY:
As operations wind down and the US Military returns to a peace time footing, many providers will be asked to care for more veterans. This presentation will discuss military unique topics such as TBI, PTSD, and other issues commonly seen in veteran populations. Dr. Moran will discuss how his residency incorporates military specific training and demonstrate for the participants how they can get this training for their own use in practice.

SYMPOSIUM 16

ASSISTED DYING FOR PSYCHIATRIC PATIENTS IN THE NETHERLANDS: POSSIBLE IMPLICATIONS FOR THE UNITED STATES?

Chair: René Cornelis Antonius de Veen, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the ethics and procedures concerning physician assisted suicide as they are used in the Netherlands, as well as the positions of stakeholders and the complex moral issues involved; 2) Unbearable suffering from psychiatric illnesses does exist in de USA. Participants are requested to recognize this and engage in a discussion on this issue; 3) What can the US Mental Health Care learn from The Netherlands? How do US colleges think they would react to a request for assisted suicide?

SUMMARY:
Physician assisted suicide (PAS) in somatic healthcare in the Netherlands has become a more or less undisputed right for patients with a terminal disease who's suffering is unbearable and who have no reasonable perspective for cure and very low quality of life. PAS is much more controversial in psychiatric illnesses.

Psychiatric illness in itself does not lead to a 'terminal condition' but suicide rates are higher than average in a number of diseases. Among these are depression and schizophrenia. Suffering can be unbearable due to the nature of the illness itself, but also the lack of perspective and quality of life.

In Dutch healthcare the awareness of this and the developments in somatic healthcare with PAS, have opened the door for psychiatric patients to request for help from their doctor in dying in a dignified way.

PAS is not lightly provided, a thorough assessment is required. Actual suicidality and possible options for treatment should have been assessed. Only after a long and elaborate process the doctor can offer his help in the assisted suicide.

S16-1.
THE ROLE OF SCEN DOCTORS: A CASE REPORT

Presenter: Sytske van der Meer, M.D.

SUMMARY:
In the Netherlands physician assisted suicide (PAS) still is highly controversial, but the attitude of psychiatrist towards this issue is gradually changing. This is due to a number of factors. One of these is the mediating role of SCEN doctors who have contributed to the growing acceptance that patients with a serious psychiatric condition have the right to a dignified death. SCEN stands for Stichting voor Consultatie bij Euthana sie in Nederland, Foundation for consultation with euthanasia in the Netherlands.

We present a case report that illustrates the moral and ethical difficulties that can arise.

The case is about a sixty year old woman suffering unbearably from her lifelong schizoaffective disorder and who had lived in a psychiatric hospital for the most part of her life.

She was rendered assistance by her suicide by her psychiatrist. She died in peace, maybe more dignified even than she had ever managed to live.

S16-2.
ASSISTED SUICIDE FOR PSYCHIATRIC PATIENTS FROM A PATIENT ADVOCATE PERSPECTIVE

Presenter: Petra de Jong, M.D.

SUMMARY:
Physician Assisted Suicide (PAS) in the Netherlands has become a right for patients with a terminal somatic illness. The NVVE (Dutch Right to Die Society) has been a strong advocate for this right for many years. For us it seemed unjust to not grant similar rights to patients with severe mental disorder who had a consistent death wish. That is why we have strongly promoted this right for them the last couple of years.

Steps forward to change this situation have been made by professionals, but at this moment the number of cases in somatic healthcare where PAS is delivered exceeds that of psychiatric cases a thousand fold.

The moral dilemmas involved in PAS for doctors are sometimes so big that they do not want to respond to the request. For these cases the End of Life Clinic has been created. The background and procedures of this clinic will be described and the moral and ethical issues that arise in the process of rendering assistance are addressed.

S16-3.
DIAGNOSTIC ISSUES N ESTABLISHING THE VALIDITY OF A WISH TO DIE

Presenter: Lia Verlinde, M.D.

SUMMARY:
Establishing the consistency and credibility of a death wish in the case of a patient with a psychiatric disease requires a thorough diagnostic process. Complex moral and ethical issues are involved. In this diagnostic process the psychiatric condition is extensively assessed, the depth of the death wish is 'weighed' and the moral and ethical issues are addressed. Contacts with important people who are involved are established. Among these are family and partner, the general practitioner and in complex cases a second psychiatrist or other specialist. Actual suicidality should be excluded and all treatment options have to be fulfilled. Only after this long and elaborate diagnostic process, when all questions have been answered, the doctor can offer his help in the assisted suicide. And even after this process a second opinion is required before the assistance can actually be rendered.

Sunday, OCT 13, 2013

SYMPOSIUM 017

PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT UNDER THE ACA

Chair: Laura F McNicholas, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the ACA; 2) Understand how health exchanges will influence psychiatric practice; 3) Explain how Medicaid and Medicare will be managed under the ACA.

SUMMARY:
After a brief introduction by Dr. McNicholas, Drs. O'Brien and McLellan will lead an informative discussion regarding parity for psychiatric diagnoses and the impact of the Affordable Care Act (ACA). The panel will then address the practice and economical concerns and issues associated with implementation of the ACA. The implications for treatment and treatment options will be detailed and followed by a further discussion that will include the timeline of implementation of the ACA. How this effects changes within DSM-V on practice and the ACA will be discussed.

S17-1.
PARITY FOR PSYCHIATRIC DIAGNOSES AND THE IMPACT OF THE AFFORDABLE CARE ACT (ACA)

Presenter: A. Thomas McLellan

SUMMARY:
Drs. O'Brien and McLellan will discuss parity for psychiatric diagnoses and the impact of the Affordable Care Act (ACA). The practice and economical issues associated with implementation of the ACA will be addressed. Implications for treatment and treatment options will be addressed. Further discussion will include the timeline of implementation of the ACA. Effects of changes within DSM-V on practice and the ACA will be discussed.

S17-2.
PRACTICE AND ECONOMIC ISSUES ASSOCIATED WITH IMPLEMENTATION OF THE ACA

Presenter: Charles P O'Brien, M.D., Ph.D.

SUMMARY:
Drs. O'Brien and McLellan will discuss parity for psychiatric diagnoses and the impact of the Affordable Care Act (ACA). The practice and economical issues associated with implementation of the ACA will be addressed. Implications for treatment and treatment options will be addressed. Further discussion will include the timeline of implementation of the ACA. Effects of changes within DSM-V on practice and the ACA will be discussed.

S17-3.
PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT UNDER THE ACA

Presenter: Laura F McNicholas, M.D., Ph.D.

SUMMARY:
Dr. McNicholas will be introducing Drs. McLellan and O'Brien to discuss in depth with the audience the Affordable Care Act (ACA). Attendees will gain an understanding of how health exchanges will influence psychiatric practice in the future. By the conclusion of the session, attendees will be able to explain how Medicaid and Medicare will be managed under the Affordable Care Act (ACA) and how this legislation will impact their practice and/or their institution.

SYMPOSIUM 18

THE CHALLENGE OF OLMSTEAD VERSUS L.C.: A PILOT PROGRAM TO IMPROVE LONG-TERM PSYCHIATRIC INPATIENT CARE AND PROMOTE COMMUNITY REINTEGRATION

Chairs: Mary F Morrison, M.D., M.S., Paul Grant, Ph.D.

Discussant: George C. Gardiner, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the decision in Olmstead v. L.C. and the implications for patients with chronic mental illness on long term inpatient settings; 2) Review the psychiatric and medical characteristics of patients in long term inpatient settings and the challenges in assisting them with successful and meaningful community residence and participation; 3) Describe the training and implementation of Recovery-Oriented Cognitive Therapy in a long term psychiatric unit and the successes and challenges that accompanied this process; 4) Review overall outcome data from the pilot program including length of stay, patient satisfaction as well as case reports of successes and issues.

SUMMARY:
In the wake of de-institutionalization, a mandate of community behavioral health care is helping patients with persistent schizophrenia requiring long-term hospitalization become reintegrated into the community. Here, we describe an ongoing innovative inpatient psychiatric pilot program which begins in the inpatient setting. The objectives of this collaborative venture were to develop and implement a comprehensive multidisciplinary treatment program which incorporated standardized assessments, recovery-oriented treatment, Cognitive Therapy, and the integration of families, community supports, and medical and aftercare providers. The program was designed to provide patients with individualized recovery-oriented treatment that promote smoother transition into the community. We anticipated several positive outcomes pertaining to the overall quality of psychiatric and medical care at the onset in 2011. We also anticipated that patients participating in this comprehensive recovery oriented program would enjoy a greater clinical success, as measured by a shortened length of time spent hospitalized (LOS), improved continuity of care, and successful community reintegration. In order to fully capture the scope of the pilot program, several contributors will discuss their involvement and unique roles as participating members delivering specialized care and services to the patients throughout the implementation of the program. First, Cummings and Crowne will present the general background and scope of the pilot program, the standard treatment prior to implementing the pilot program, and the role of the non-psychiatric physicians and psychiatrists in providing integrated care within this new treatment environment. Next, Simmons et al. will discuss the details of implementing the therapeutic model for the pilot program. Specifically, they will explore the collaborative process used in the development and implementation of Recovery-Oriented Cognitive Therapy (CT-R) on an inpatient setting, with emphasis on challenges overcome. Involvement of peer therapists on the inpatient unit and coordination with outpatient teams will be considered. Finally, Dr. Gardiner, the discussant, will present and discuss outcome data from the program, including: average Length of Stay (LOS), individual and collective anecdotal information, and formal measures of clinical status. We hope to invite discussion on the evolving nature of psychiatric care and the challenges inherit in delivering optimal psychiatric care in the face of community and fiscal realities.

S18-1.
EXTENDED ACUTE UNIT PILOT PROGRAM OVERVIEW

Presenter: Wanda Cummings, B.A., M.S.W.

SUMMARY:
Over a period of two years, Behavioral Health Officials in Philadelphia reviewed the effectiveness of the EAC (Extended Acute Unit) programs and determined that changes were needed to facilitate quicker and sustainable transition of patients into the community. Subsequently, key staff of the Temple University Hospital-Episcopal (TUH-E) Campus, the Department of Psychiatry at Temple University, the Beck Initiative staff of the University of Pennsylvania Perelman School of Medicine, and an Assertive Community Treatment (ACT) Team collaborated to develop the EAC Pilot Program at TUH-E which started in July 2011 and took place on one of two EAC units. The background and scope of the pilot program will be reviewed. We anticipated that pilot patients would enjoy greater clinical success, as measured shortened LOS, patient satisfaction scores, positive, negative and depressive symptoms scores and successful community reintegration.

S18-2.
PHYSICIAN ROLE AND PILOT PROJECT IMPLEMENTATIONS

Presenter: Mary F Morrison, M.D., M.S.

SUMMARY:
Psychiatric and medical characteristics of EAC patients on both the Pilot project unit and the Standard of Care Unit are presented. Successes, as well as challenges, faced in facilitating the rehabilitation and return to the community of the patients living with Severe and Persistent Mental Illness. New relationships with primary care physicians dedicated to providing ongoing integrated medical health care to patients with complex medical co-morbidities and community-based treatment providers were developed. Experience working with city and government agencies that provide appropriate housing placement in the community for patients following their discharge from the EACs. Data pertaining to the use of Pro Re Nata (PRN) medications and restraints in each group of patients over time are presented.

S18-3.
RECOVERY-ORIENTED COGNITIVE THERAPY (CT-R) THEORY AND IMPLEMENTATION ON A LONG-TERM UNIT

Presenter: Katie P. Daly, Psy.D.

SUMMARY:
CT-R, developed by Dr. Aaron Beck and colleagues, is a treatment approach that fuses the Recovery movement's spirit and cognitive therapy's evidence base to collaboratively help individuals with persistent schizophrenia attain personally set goals, remove obstacles to the goals, and engage in their own psychiatric rehabilitation. The consultation group initially provided Cognitive Behavioral Strategies for the Inpatient Milieu training which consisted of 20-hour workshops and a 6 month consultation period. The workshops were given to multidisciplinary staff on all three shifts, including mental health workers, certified peer specialists, registered nurses, social workers, psychiatrists, clinical psychologists, office support staff, and the ACT Team staff. This training program was later updated to fully incorporate recovery principles and evolved into the CT-R program which is now the therapeutic modality for the pilot program.

S18-4.
HOW THE PILOT PROGRAM WAS IMPLEMENTED

Presenter: Williametta Simmons, Psy.D.

SUMMARY:
The unit psychologist will address the specifics of implementing the pilot program, emphasizing challenges overcome. It was necessary to obtain buy-in and commitment from the leadership of various agencies, as well as frontline staff and patients. The second and critical step involved the systematic dissemination and integration of Cognitive Behavioral Strategies, and later CT-R, into the already existing illness management psychiatric rehabilitation model. To reflect CT-R and other elements of the Pilot Program, existing treatment plans and multidisciplinary progress notes were revised. To insure sustainability of the program, staff members who were proficient in CT-R worked with the consultants to develop continuing training modules. Major challenges overcome by the EAC Pilot Program include: a) eliciting mutually agreed upon goals of the Pilot Program and commitment from all agencies; b) developing continuing training modules with PENN consultants and others.

WORKSHOPS

THURSDAY, OCTOBER 10, 2013

WORKSHOP 01

WELLNESS FROM WITHIN: RESIDENT-LED WELLNESS INITIATIVES IN THE HARVARD LONGWOOD PSYCHIATRY RESIDENCY

Chair: Hannah H Larsen, M.D.

Presenters: Hannah H Larsen, M.D., Marisol A. Segundo, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify need for physicians and physicians-in-training to engage in self-care activities to improve personal wellness; 2) Consider ways in which residency programs can support resident wellness through educational and/or experiential interventions; 3) Consider challenges and barriers to implementing wellness initiatives within residency programs or in other settings.

SUMMARY:
Physician well-being is an issue that has garnered significant attention in recent years, particularly with respect to how physician burnout affects patient care. Burnout has been defined by Maslach and colleagues (1996) as "emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment due to work-related stress" and has been well-documented in residents across specialties. Other outcomes that have caused the field to take notice include significantly elevated rates of suicide and substance abuse among physicians. While a growing body of research supports a link between factors contributing to these negative outcomes, studies on the effect of interventions to prevent or modify these risks are limited. The term wellness has been used to emphasize the cultural shift in medicine from merely an absence of disease or pain to a state of physical, mental and social well-being. However, medical education has traditionally neglected the pursuit of personal wellness in favor of patient wellness. But given that medical training is typically a time of considerable challenge, it may be that this is precisely the time when these issues should be emphasized and addressed.

Psychiatry training involves challenges both unique and common to all who pursue a career in medicine. In addition to time pressures, sleep deprivation, fear of and experience of adverse outcomes, exposure to human suffering, and lack of mastery, psychiatry residents often experience heightened emotional connections with patients, limited resources, violence and threat of violence, patient suicide and threat of suicide, and more frequent interaction with patients with hostile or "difficult" personality types.

In an effort to bolster the morale of its trainees, the Harvard Longwood Psychiatry Residency Training Program (HLPRTP) sought resident input on potential interventions. Hannah Larsen, HLPRTP PGY4, will discuss the resulting conceptualization and implementation of two resident-led initiatives: 1) an overnight retreat, and 2) a wellness workshop series. She will illustrate how the programming of each addressed the stated objectives and will provide a brief description of the logistical challenges. She will present resident feedback as well as outcome data (analysis currently pending) on burnout and health behaviors collected from several residents who attended the workshops. Finally, she will engage the audience in discussion about future directions for such programs and how to facilitate successful adoption in other programs.

Marisol Segundo, HLPRTP Associate Training Director and Chair of the Curriculum Committee, will describe how the program administration guided and facilitated the implementation of these initiatives. She will highlight the benefits and challenges of such a resident-led approach and then will lead discussion about how other residency programs might foster similar initiatives.

WORKSHOP 02

PERSON-CENTERED RISK MANAGEMENT AND MALPRACTICE ISSUES IN EMERGENCY PSYCHIATRY

Chair: John S. Rozel, M.D.

Presenters: Michael James Sacopulos, J.D., Kim D. Nordstrom, J.D., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the legal, interpersonal and economic aspects of medical malpractice litigation; 2) Understand the different impacts of quality of care, outcomes, and therapeutic relationships have on litigation risk and outcome; 3) Learn how recovery and person centered techniques (e.g., shared decision making, safety planning, and involvement of natural supports) can decrease liability risk; 4) Learn basic tactics to defuse upset consumers and families and how to document those interactions; 5) Learn how to develop and sustain written and electronic medical records that accurately document care in a style that decreases risk for litigation .

SUMMARY:
This workshop will explore strategic and tactical issues in risk management in the psychiatric emergency setting with an emphasis on effective documentation and integrating the recovery model into emergency care. While psychiatric malpractice risk is low compared to other specialties, the emergency setting is fraught with risk. Pressure to maintain flow, a rapid pace, brevity of contact with patients, limited collateral, risk of deception by patients and collateral informants, and other factors combine to create elevated risk for providers and hospitals.

The core elements of a malpractice case, also known as the "four D's" (duty, dereliction, direct causation, compensable damages) are, ultimately, only truly relevant during an actual trial. To prevent a case even being filed requires attention to different elements (an alternative "Four Ds") including the disappointment and disgust of a consumer or family member (the anger that motivates them to meet with an attorney), perception of "deep pockets" (motivates an attorney to invest time in exploring the case), and documentation (the quality of which signals to the attorney how easily a case could be won).

While the majority of malpractice cases are dropped, dismissed or resolved in favor of the physician, the process is lengthy and stressful for any defendant. The old-school concept of practicing "defensive medicine" in hopes that it will successfully win a case in a court room is a losing strategy. The best strategy is to minimize the risk of any litigation by mitigating animosity when possible and maintaining a medical record that reflects outstanding care and will, hopefully, lead to a quick litigation resolved in favor of the physician. Put simply: practice defensive documentation, not defensive medicine.

Many elements of person centered care and the recovery model lend themselves strategic mitigation of risk. When carefully documented, these same processes provide persuasive support to a physician's case. Important elements include shared decision making, engaging natural supports and family as collateral and collaborators in treatment and decision making, developing safety plans and not contracts for safety, and reconciling conflict after mistakes or at times of disagreement.

Documentation is often the most persuasive evidence before a jury or judge. Beyond fundamental documentation standards (e.g., legible, complete, timely, clear, unaltered) there are several other important elements of documentation applicable to high risk settings such as documenting decision making, informed consent discussions, collaboration with other providers, and interactions with consumers and family. Guidelines for and examples of effective and ineffective documentation will be shown with special reference and consideration given to the role and impact of electronic medical record and computerized provider order entry systems.

WORKSHOP 03

"BUT YOU HAVE SCHIZOPHRENIA, WHY WOULD YOU SMOKE MARIJUANA?"

Chairs: Thomas E. Brouette, M.D., Ryan Hashem, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Appreciate the interaction of schizophrenia and cannabis use/dependence on their respective clinical courses; 2) Consider how to engage a patient who believes their pharmacological intervention is as sound as yours; 3) Formulate several approaches to motivating a patient to reconsider the relationship between their emotional state, their substance use and their illness.

SUMMARY:
Marijuana is a drug that has long been associated with exacerbating psychotic symptoms and hampering recovery from mental illness. Yet despite these findings, multiple studies have found that marijuana use is significantly more common among individuals with schizophrenia than the general population. Cannabis use likely not only hastens the course of schizophrenia, but their mental illness also makes the patient even more vulnerable to the emotional and economic impact of substance use.

Psychiatrists are often treating patients with two active diagnoses, schizophrenia and cannabis abuse/dependence, who perceive themselves as having neither, much less one exacerbating the other. To engage, motivate and care for a patient with these two diagnoses requires integrating elements of psychopharmacology, motivational interviewing and rehabilitation skills in order to ensure the best outcome. Audience members are encouraged to join the presenters in a sharing their experiences caring for these patients and discussing approaches to some of the clinical challenges which arise.

WORKSHOP 04

USING EMPIRICAL CLINICAL PRACTICE DATA TO IMPROVE CARE FOR SERVICE MEMBERS

Chairs: Joyce C West, M.P.P., Ph.D., Joshua Wilk, Ph.D.

Presenters: Charles W. Hoge, M.D., Joyce C West, M.P.P., Ph.D., Farifteh Duffy, Ph.D., Joshua Wilk, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand how the Army has used systematic clinical practice data collected from behavioral health clinicians to inform policy and improve care for service members, particularly for PTSD patients; 2) Identify key factors affecting treatment access and quality for service members receiving behavioral health treatment in the army; 3) Understand current rates of use of evidence-based prac-

tices with respect to patient assessments and treatment for substance use disorders among service members.

SUMMARY:
This workshop will highlight how systematic clinical practice data collected from behavioral health clinicians through the WRAIR Army Behavioral Health Practice and Treatment Study have been used by the Army to inform policy and improve care for service members. A major focus will be on describing how findings related to the assessment and quality of treatment for post-traumatic stress disorder were specifically used to inform the Department of the Army's Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder. In addition, key findings focusing on clinicians' reports of factors affecting treatment access and quality for a systematically selected sample of service members receiving behavioral health treatment in the army will be presented, along with clinical practice findings related to quality of assessments and treatment for substance use disorders in Army behavioral healthcare settings. The implications of these findings for strengthening services delivery and clinical practice in the Army in order to improve care for service members will be discussed.

The format of the workshop will consist of an introduction and three brief presentations. After each presentation, the session co-chairs (Joshua E. Wilk, PhD and Charles W. Hoge, MD) from the Walter Reed Army Institute of Research (WRAIR) will lead a discussion focusing on the implications of the findings presented for policy and clinical practice. There will be ample time allocated for questions and comments from attendees after each presentation.

I. Background and Introduction: Using Empirical Clinical Practice Data to Inform Policy and Improve Care for Service Members (5 minutes)

Joshua E. Wilk, PhD

II. Case Study: Examination of Practices and Patterns of Evidence-Based Treatment for PTSD and the Army's New Policy on Assessment and Treatment of PTSD (15 minute presentation and 10 minutes of discussion)

Charles W. Hoge, MD and Joshua E. Wilk, PhD

III. The Perspective of the Army's Behavioral Health Clinicians: Systematic Data on Mental Health Treatment Access and Quality (15 minute presentation and 10 minutes of discussion)

Joyce C. West, PhD, MPP, Joshua E. Wilk, PhD, Donald S. Rae, M.S., Farifteh F. Duffy, PhD, Eve K. Mo?cicki, ScD, MPH, S. Janet Kuramoto, PhD, MHS, and Charles W. Hoge, MD

IV. Quality of Assessments and Treatment for Substance Use Disorders in Army Behavioral Healthcare

(15 minute presentation and 10 minutes of discussion)

Farifteh F. Duffy, PhD, Joshua E. Wilk, PhD , Joyce C. West, PhD, MPP, Janet Kuramoto, PhD, MHS, and Charles W. Hoge, MD

V. Concluding Comments and Discussion (10 minutes)

Joshua E. Wilk, PhD and Charles W. Hoge, M.D.

WORKSHOP 05

NPS ARE FROM MARS, PSYCHIATRISTS ARE FROM VENUS: SHARED TRAINING EXPERIENCES AND COLLABORATIVE PRACTICE

Chair: Patrick S. Runnels, M.D.

Presenters: Rosa Ruggiero, M.S.N., N.P., Patrick S. Runnels, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Develop a basic understanding of training and practice for psychiatric advanced practice nurses; 2) Describe multiple models for shared training experiences between psychiatrists and psychiatric APNs, as well as to describe the value of such experiences on both professions; 3) Understand how multidisciplinary, collaborative learning environments can prepare clinician leaders to more effectively meet the needs of patients; 4) Develop a foundation for discussing the future of collaborative working relationships between psychiatrists and psychiatric APNs.

SUMMARY:
Over the past 5 years, psychiatric nurse prescribers have grown to represent more than one third of the graduating psychiatric workforce each year. Yet, despite representing an increasing share of the workforce, studies suggest that physicians remain unclear and misinformed about relevant practice issues for advanced practice nurses, and have little sense of how collaborative care models can and should work. Developing shared training experiences could go a long way toward helping to address these issues, and potentially improve the overall delivery of mental health care, but a literature search prior to 2013 reveals absolutely no articles in the medical literature outlining any such programs. In this presentation, we will explore key aspects of APN training and practice across the country. Then we will outline a novel approach to shared training: the inclusion of psychiatric advanced practice nurses in public and community psychiatry fellowship training programs. We will highlight the results over two years of this intervention, discuss the ramifications on the overall practice of psychiatry, and suggest multiple models for expanding future shared training experiences.

WORKSHOP 06

CONTAINING THE CYBER BULLY, TREATING THE VICTIM: FROM KINDERGARTEN TO CORPORATION

Chair: cheryl d wills, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the phenomenology of electronic harassment, and the costs of cyber bullying to individuals, families, and society; 2) Use evidence-based psychiatry to identify, evaluate, and rehabilitate cyber bullies and their the victims; 3) Identify behaviors that suggest a person is engaging in cyber bullying or being victimized by a cyber bully; 4) Identify laws and policies that are relevant to containing cyber bullying in their local communities including, when applicable, reporting obligations; 5) Identify resources that may be used to educate and empower their patients who are being harassed electronically.

SUMMARY:
Cyber bullying has gained notoriety in academic, healthcare, and corporate settings and in the media. This interactive multimedia workshop is designed to educate clinicians about the psychiatric manifestations of cyber bullying, including identifying and rehabilitating the perpetrators, and treating and empowering the victims.

The presenter is a general and child forensic psychiatrist who works with victims and perpetrators of electronic harassment in educational, legal, and corporate settings. About 2/3 of the workshop will focus on cyber bullying in students from kindergarten to college, and the remainder will address cyber bullying among employees in healthcare and other corporate settings. The presenter will describe various types of electronic harassment, including cyber stalking, and cyber bullying. The phenomenology of cyber bullying and its manifestations on students, families, and society will be examined. Participants will be introduced to recent research involving cyber bullying, students, sexting, and electronic harassment. Workshop participants will develop an appreciation for the goals and motivations of cyber bullies as well as why cyber bullying may appeal to otherwise nonviolent individuals. The workshop will help participants understand how cyber bullies identify potential victims and the psychological, social, and physical effects of cyber bullying on victims and their families. The connection between cyber bullying and suicide will be examined. Cyber harassment in healthcare and corporate settings will be addressed from the perspectives of the perpetrator and the victim. The effect of workplace and personal trauma will be used to examine how the workplace culture and vicarious trauma may influence how one responds to electronic harassment.

Forensic aspects of cyber bulling will be examined, including an historical perspective, federal policy, landmark legal cases, and existing state laws and policy. A five-step plan for rehabilitating perpetrators and treating victims will be introduced and participants will be encouraged to work through case examples. Participants will use case examples to (1)identify, (2)assess, (3)educate, (4)treat, and (5)empower victims of cyber bullying and to rehabilitate perpetrators.

WORKSHOP 07

CASTAWAYS: ADDRESSING HOSTILITY AND HELPLESSNESS IN SEVERELY LONELY ADULTS

Chair: Sheila Maria LoboPrabhu, M.D.

Presenters: Ali Abbas Asghar-Ali, M.D., Ellen F Barr LCSW, L.C.S.W.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize Bartholomew and Horowitz's four attachment prototypes; 2) Identify themes of hostility and helplessness in lonely patients with anxious and avoidant attachment prototypes; 3) Describe the three psychological needs which must be attained for psychological well-being; 4) Apply knowledge about self-psychology and attachment research to psychiatric care of the lonely suicidal patient.

SUMMARY:
Hostility and helplessness are recurrent themes in severely lonely adults. Lyons-Ruth identified hostile intrusiveness and helpless withdrawal by the parent as two patterns of parent-child mis-attunement which may lead to infant disorganization. In our work with severely lonely suicidal adults, we have noted the triad of loneliness, hostility, and helplessness in adults with anxious attachment (Bartholomew and Horowitz's preoccupied and fearful subtypes) and avoidant attachment (dismissive subtype). Hostility and helplessness can be both causes and effects of subjective feelings of loneliness; for example, a) lonely individuals' attempts to angrily coerce the world to fit their view in order to cope with cognitive dissonance between their own perception and reality, and b) Seligman's "learned helplessness" theory in severely lonely, depressed persons. Segments from the movie "Castaway" will be used to illustrate hostility and helplessness in a severely lonely person as depicted by Tom Hanks. Ryan and Deci proposed that the three core psychological needs of autonomy, competence and relatedness must be met in order to experience psychological well-being. In our two case presentations, we will demonstrate a successful four-step treatment model to treat lonely, suicidal patients. The steps are 1) addressing hostility and

helplessness, 2) identifying their causes and effects in lonely patients, 3) meeting patients' three psychological needs, and 4) working toward forming a stable self via validation, mentalization, reality orientation, and socialization.

WORKSHOP 08

PERINATAL PSYCHIATRIC DISORDERS: RECOGNITION AND MANAGEMENT A COLLABORATIVE MODEL

Chairs: Jayaprabha Vijaykumar, M.D., M.P.H., Shalice D. McKnight, D.O.

Presenters: P. Lynn Ouellette, M.D., Deborah R. Kim, M.D., Consuelo C. Cagande, M.D., Robin Perry, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Have an enhanced understanding of maternal physiology and psychology, before, during, and after pregnancy; 2) Discuss the risks of untreated mental illness treatment options during pregnancy; 3) Discuss some of the obstacles to care for women with perinatal mood disorders. Demonstrate how this project has addressed ways to diminish some of these obstacles; 4) Explore possible collaborations across medical fields to care for this population by looking at public health program models in practice.

SUMMARY:
Perinatal psychiatry is described as "promoting the understanding of maternal physiology and psychology, before, during, and after pregnancy…" As a field, perinatal psychiatry aims to bridge the gap between obstetrics, psychiatry, and pediatrics in helping the pregnant patient have a more streamlined and comprehensive care"(July 2012 issue of the Psychiatric Annals).The pathophysiology and treatment of Postpartum depression and psychosis have been subjects of explosive research in recent years. According to the WHO, 10% of pregnant women, and 13% of those who have given birth, experience some type of mental disorder, most commonly depression and anxiety (www.who.int November 24, 2011). This period of emotional tumultuousness is biologically, psychologically, and socially based. It is marked by a significant hormonal flux in the pregnant female, which when coupled with several behavioral and psychological changes necessary for maternal care of infant, can result in a wide range of psychiatric illnesses. For example, recent epidemiological studies have found high risks of onset or recurrence of bipolar disorder episodes soon after childbirth (May 2012 issue of Psychiatric Annals).In this workshop, psychopharmacological interventions such as SSRIs, mood-stabilizers, and atypical anti-psychotics during the peri-partum period will be explored from clinical and research perspectives, including types and dosages of medications based on not just their teratogenicity in fetuses, but on fertility in the non-pregnant female as well. The APA's recognition of this need for comprehensive care has given rise to funding for public health programs such as the Maine Association of Psychiatric Physicians' Postpartum Depression Project. It addresses the diagnosis and under treatment of postpartum depression and the longtime serious adverse effects of maternal depression on women and their children. The focus of this project has been to provide public education and training programs across medical and mental health specialties and easy access to materials to aid in the screening, assessment and treatment of women who experience mood and anxiety disorders during the perinatal period. The ultimate goal has been to increase the early recognition and treatment of perinatal mood disorders and to improve collaboration between providers involved in the care of these women. Obstetricians, faced with psychiatric syndromes of patients in the perinatal period, are incorporating detection and early treatment by the integration of psychiatric assessments and timely mental health interventions into their practice guidelines. This workshop aims to offer new perspectives and stimulate discussion with the goal of forming collaborations across disciplines to better streamline the multifaceted care required in treating perinatal psychiatric disorders. A multidimensional approach becomes not just optimal, but vital, in ensuring the safety and well-being of mothers and their children.

WORKSHOP 11

THE FUTURE IS NOW: INTEGRATED CARE AND MEDICAID MENTAL HEALTH HOMES

Chair: Patrick S. Runnels, M.D.

Presenters: Jim Penman, Beth Trecasa, M.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the overall concept and value of a Mental Health Home; 2) Describe potential variations and pitfalls for implementing Mental Health Homes; 3) Identify points of synergy between Mental Health Homes and integrated health care delivery; 4) Identify points of interaction and conflicts between Mental Health Homes and health homes run out of other settings.

SUMMARY:
Among many programs initiated by the Affordable Care Act, health homes are among the most exciting, providing states with the opportunity to transform the way health care is delivered to the Medicaid population. States were given authority to initiate and develop health home programs in a number of settings, and at least one state opted to focus on community mental health settings: implementation of these Medicaid Mental Health Homes in Ohio began in October 2012. In this presentation, we will explore the concept of health homes – particularly Mental Health Homes – and explore an example of their implementation at a community mental health center – The Centers For Families and Children. Additionally, the Centers partnered with The Cleveland Clinic to pilot a model of reverse integration through one of the original SAMHSA integrated care grants. We will further define differences and explore the synergy between models of integrated care and mental health homes, and discuss future directions for these programs.

WORKSHOP 12

PSYCHOGENIC NONEPILEPTIC SEIZURES: WHAT DOES A PSYCHIATRIST DO ONCE THE DIAGNOSIS IS MADE?

Chairs: Andres M. Kanner, M.D., W Curt LaFrance Jr, M.D., M.P.H.

Presenters: W Curt LaFrance Jr, M.D., M.P.H., Andres M. Kanner, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize the signs, symptoms and history associated with the presentation and diagnosis of nonepileptic seizures (NES); 2) Discuss the diagnosis of NES with patients and families to enable acceptance of treatment; 3) Recognize the management options available for patients with NES and their families.

SUMMARY:
Psychogenic nonepileptic seizures (NES) present with a combination of neurologic signs, underlying psychological conflicts and comorbid psychiatric disorders. For more than a century, neurologists and psychiatrists have accumulated data and insights about the phenomenology, epidemiology, risks, comorbidities, and prognosis of NES. The gold standard of video electroencephalography and adjunctive tests are used in establishing the diagnosis of NES, which has also been instrumental in demonstrating the difference between epileptic seizures and NES. Patients with NES share some commonalities in their histories, including a history of abuse, depression, post-traumatic stress symptoms, and dissociation. Once the diagnosis of NES is made, patients often refuse to accept the diagnosis and to follow recommendations for treatment. Other barriers arise with lack of communication or disagreement between the mental health professionals and the neurologist regarding assuredness of the diagnosis. The role of the neurologist and mental health providers in the diagnosis and management of these patients will be discussed. The common obstacles that preclude a proper treatment will be reviewed. The similarities and differences of these problems in the adult and pediatric patient with NES will be discussed. Directions for research in the diagnosis and treatment of NES will also be reviewed.

WORKSHOP 13

INTRODUCING STUDENT DOCTORS TO COMMUNITY PSYCHIATRY AND SERIOUS MENTAL ILLNESS

Chairs: Ann L. Hackman, M.D., Constance Nicole Lacap, D.O.

Presenters: Kathleen M. Patchan, M.D., Christopher M. Wilk, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify approaches to introducing medical students to people diagnosed with serious mental illness and helping students understand challenges these individuals face in the community; 2) Discuss the implications of early medical student experience with people diagnosed with serious psychiatric illness in reducing stigma, encouraging person centered care and facilitating recovery; 3) Discuss importance of training all physicians in recognizing and appropriately addressing health issues commonly seen in people in treatment in community psychiatry settings.

SUMMARY:
The University of Maryland School of Medicine Department of Psychiatry, a program based in urban Baltimore, has a long history of commitment to training in public sector psychiatry and to innovative approaches to medical student education. Given that people with serious and persistent mental illness have frequent co-occurring medical diagnoses, experience barriers to medical care die an average of more than 20 years younger than the general population, it is essential that all future physicians have an understanding of and respect for this population.

Focus in our program over the past decade has involved increasing attention to early exposure of medical students to people receiving treatment in community psychiatry. Major initiatives for this exposure include the Combined Accelerated Program in Psychiatry (CAPP) program an intensive preclinical exposure to psychiatry, particularly public sector psychiatry. During the psychiatry module of their introduction to clinical medicine, each second year medical student interviews a person receiving community psychiatry services. During their course of study in pathophysiology and therapeutics, consumer narratives constitute a substantial portion of small group medical student teaching. The third year psychiatry clerkship involves exposure to community psychiatry through each of the clerkship settings, and these exposures are supplemented with opportunities for time with specialized programs such as assertive community treatment.

We have found mental health consumers extremely willing and often eager to participate in training young physicians

and to share their experiences. Further student doctors have been extremely receptive to meeting people who have been diagnosed with psychiatric illnesses and report this as an important and memorable part of their training, particularly during the pre-clinical years when students have limited clinical contact. In our experience early positive exposure to people with psychiatric illness helps to inform physician practice as young doctors proceed through training and we believe that it has positive impact in reducing stigma and decreasing barriers to care

With our audience, we will explore approaches to providing student doctors with early, informative experiences with people with serious mental illness. Further we will discuss the potential benefits of this collaboration both young doctors and for the consumers of mental health services

WORKSHOP 14

IMPLEMENTING PSYCHIATRIC ADVANCE DIRECTIVES IN A COMMUNITY MENTAL HEALTH CENTER: WHERE TO START?

Chair: Rachel Zinns, M.D., M.Ed.

Presenters: Kishor Malavade, M.D., Rachel Zinns, M.D., M.Ed., David Miller, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Anticipate challenges associated with initiating a Psychiatric Advance Directives implementation plan; 2) Identify strategies for successful implementation that target administration, providers, and consumers; 3) Discuss efforts towards PAD implementation in their various treatment settings and to share experiences with different implementation strategies.

SUMMARY:
Consumer autonomy, improved treatment adherence, enhanced treatment alliance, and reduced violence are among the many supposed benefits of psychiatric advance directives (PAD) at the intrapersonal, interpersonal, and service system levels. Despite reports of these and other benefits of PAD, strong consumer interest in PAD, and national policy oversight moving towards a standardization of PAD, their use has not been widespread. Indeed, there have been numerous reports in recent years of consumer and clinician attitudes regarding PAD, content of PAD documents, and factors relating to their completion process. Yet little has been written about the implementation of PAD at the organizational level, especially with regard to dissemination and access to documents and the honoring of PAD.

We present a model of PAD implementation that addresses administrative and legal issues, documentation and dissemination through EMR, provider training and increasing provider readiness, consumer education, and peer-advocates' training. We describe our efforts to tailor implementation strategies to both perceived and real-time barriers. Strategies which were most helpful, as well as obstacles and resistance frequently encountered, will be highlighted. We report on the process of evaluating various implementation and intervention strategies, focusing on the relationship of implementation strategies to clinician, patient, and service system outcomes.

We will encourage participants to discuss their experiences with PAD implementation. Especially because there is little guidance in the literature about preparing consumers and providers for PAD implementation, we hope to provide a forum for sharing tips from successful implementation efforts, problem-solving for challenges faced by participants, networking, and information-exchange.

WORKSHOP 9

MOTIVATIONAL INTERVIEWING IN EVERYDAY PSYCHIATRIC PRACTICE: A HANDS-ON INTERACTIVE WORKSHOP

Chairs: Petros Levounis, M.A., M.D., Carla B. Marienfeld, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) List the four fundamental principles of Motivational Interviewing; 2) Use Motivational Interviewing approaches in everyday clinical practice; 3) Integrate Motivational Interviewing psychotherapy with psychopharmacological interventions.

SUMMARY:
Motivational Interviewing is deeply grounded in humanistic psychology, especially the work of Carl Rogers. William R. Miller and Stephen Rollnick propose that change is a natural and ubiquitous process that is intrinsic to each person, and may occur without any outside intervention. Motivational Interviewing seeks to hasten this natural change process by creating an interpersonal situation, wherein the patient can engage in a collaborative dialogue that supports behavioral change from the patient's perspective.

Fundamentally, Motivational Interviewing is not exactly a method or a "bag of tricks," not something that can be done to someone, but something that is done with someone, a way to be with another person that increases the likelihood they will consider and become more committed to change. Clinicians adopt a style or "spirit" of interacting and communicating with patients such that they a) honor the patient's experiences and perspective (collaboration), b) affirm the patient's right and capacity for self-direction (autonomy), and c) draw out the patient's goals, values, and perceptions that support change (evocation). This empathic stance conveys respect and acceptance of the patient and presumes that the resources for enhancing motivation reside within the patient. By creating a therapeutic atmosphere grounded in this spirit, clinicians help patients feel more open to exploring their ambivalence about change and empowered by the self-direction afforded to them.

The workshop is open to all psychiatrists who would like to learn more about the effective use of the Motivational Interviewing approach to treatment but is particularly targeted towards members in training and early career psychiatrists.

WORKSHOP 15

SHARED SPACE AND MERGING CULTURES: THE PCP-PSYCHIATRIST PARTNERSHIP

Chair: Lori E. Raney, M.D.

Presenters: Ryan Clancy, M.A., P.A., Jaron M. Asher, M.D., Lawrence A. Real, M.D., Caroline E Day, M.D., M.P.H., Jack Todd Wahrenberger, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the significant contribution of PCP – Psychiatrist partnerships in improving the health of mentally ill patients; 2) Appreciate the difficulties that can arise when these partnerships form and understand ways of trouble shooting them to develop a successful alliance; 3) Understand the psychiatrist's responsibility in actively pursuing these partnerships and provide leadership to the psychiatric team that may be resisting collaboration.

SUMMARY:
The role of the psychiatrist is shifting from an independent practitioner providing mental health treatment in the isolation of the CMHC environment to one where it is recognized that we need teams that address the treatment of both mental and physical health concerns leading to health disparities in the SMI population. Stories from the front lines of successful (and unsuccessful) partnerships with our most obvious ally, primary care providers, in this endeavor are beginning to emerge and can be a useful guide to budding partnerships nationally.

This Workshop will bring together 3 PCP-Psychiatrist partners to explore the complexities of merging the cultures of primary and behavioral health care from the medical provider point of view. This will give the audience a glimpse into the complicated and at times frustrating process of reaching across profession borders to work effectively for the benefit of patients. These selected duos represent a HRSA grantee site, a stand-alone merged clinic model and an emerging model of PCP consultation to CMHCs in Missouri. Each dyad will be given a set of 3 questions about their partnership to set the stage for a meaningful discussion of their relationship. These will include: a) describe the partnership and health care delivery arrangement in your location, b) describe the successes and challenges your team has faced in collaboration, and c) offer guidance for psychiatrists who are interested in setting up a partnership or who have been approached by primary care colleagues for assistance. The session will be moderated by Dr. Lori Raney, Chair, APA Workgroup on Integrated Care.

WORKSHOP 16

THE MEETING OF MINDS: JOINING RECOVERY IN MENTAL HEALTH AND ADDICTIONS

Chair: Hunter L. McQuistion, M.D.

Presenters: Wesley E. Sowers, M.D., Petros Levounis, M.A., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the relationship between the mental health and Addictions communities concerning respective concepts of recovery; 2) Better discern the issues in formulating recovery-orientation common to respective clinical traditions in mental health and in chemical dependency services; 3) Identify practical means through which recovery-orientation may be shared between these two traditions.

SUMMARY:
The respective professional fields of addictions and mental health have both developed concepts of "recovery." Yet, there remains struggle to reach an operational understanding of recovery and recovery-orientation acceptable to both disciplines.

This session presents an opportunity for professionals and peers to offer ideas, to debate, and to help evolve an understanding in the behavioral health community as to what recovery-orientation means in service to people with mental illnesses and people with chemical misuse disorders. The presenters will review points of similarity and difference in this regard, focusing on real life application of clinical skills and on program design.

Particularly considering a current movement toward integration of health care services that are also conceptualized as patient centered, the presenters will pursue ideas regarding how, in a practical manner, to achieve an evolutionary step in developing recovery-oriented practice that honors the values, expertise, and approaches of both fields. Broad and provocative discussion among participants will ensue about how to move these two fields forward regarding the

ideals of recovery.

WORKSHOP 17

DEADLY EMERGENCIES IN PSYCHIATRY: KEYS TO RECOGNIZE AND TREAT NMS, SEROTONIN SYNDROME, EXCITED DELIRIUM, AND OHER DISEASES THAT KILL

Chair: Kim D. Nordstrom, J.D., M.D.

Presenters: Michael Wilson, M.D., Kim D. Nordstrom, J.D., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Learn about numerous medical illnesses and conditions that may go unrecognized in a medical emergency department, with the patient being transferred to psychiatry emergency department or inpatient; 2) Learn how to recognize serious medical conditions that have psychiatric symptoms; 3) Learn when to treat and when to refer the care to medical teams; 4) Learn basic treatment of each medical condition.

SUMMARY:
This workshop will explore the numerous medical emergencies that, because of prominent psychiatric symptoms, sometimes end up being recognized on psychiatric services. Some of these conditions are related to use of psychiatric medications, such as neuroleptic malignant syndrome and serotonin syndrome but most are medical illnesses that have no relationship to psychiatry, such as excited delirium, endocrine and neurologic conditions. Each emergent condition or illness will be reviewed, to include common signs and symptoms, to aid the practitioner in recognition of the emergency. After this review, treatments will be discussed. These treatments will include immediate necessary treatment, as well as on-going treatment. In this discussion, we will also note when to treat and when to refer to our colleagues in the medical emergency department or internal medicine. The talk will be given by an emergency medical physician and an emergency psychiatrist.

WORKSHOP 18

THE IMPORTANCE OF UNDERSTANDING PRISON CULTURE FOR A COMMUNITY PSYCHIATRY SETTING

Chair: Theodora G. Balis, M.D.

Presenters: Ann L. Hackman, M.D., Curtis N. Adams, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the culture of prison life and how this may impact the people we treat in a CMHC setting; 2) Understand how the structure, expectations, and values of the prison population create a culture that is different from mainstream society; 3) Identify the additional challenges people with severe and persistent mental illness face when they are incarcerated; 4) Identify the additional challenges people with severe and persistent mental illness face on release from prison; 5) Identify the many challenges faced by community psychiatry clinicians when trying to advocate for mental health consumers who become incarcerated.

SUMMARY:
Cultural competence has been a focus for adequate treatment for people from different ethnic backgrounds and other minority groups. Cultural competence is similarly important to engagement with and understanding the values, behaviors, and challenges of people with mental illness who have spent considerable time living in an environment of incarceration in the penal system. Studies have shown that there are high rates of incarceration for people with mental illness. People with severe and persistent mental illness face unique challenges during incarceration that the general population may not encounter. They must be subjected to the dangers of the environment of jail or prison as well as navigate the limited availability of adequate treatment for their psychiatric illness. In trying to survive in jail or prison, many develop a variety of adaptations that are different from what is expected in mainstream society. The "inmate code", for example, that one must never appear weak, never "snitch", and "do your own time", sets up the values of a culture that may then change how people behave. Behaviors like intimidating others, not disclosing any information, minding one's business and not interacting with others is expected. This behavior may be adaptive and protective while incarcerated and even in some neighborhood communities, but they conflict significantly with the expectations of the mainstream community/culture and expectations in therapeutic environments. These learned values and behaviors while incarcerated interfere with post-release recovery. Mental health clinicians may also misread these as behaviors as character pathology, paranoia, resistance, manipulation, or lack of motivation for treatment. Failing to recognize these behaviors as part of their adaptation to a culture of incarceration may lead to barriers to engagement and not focusing on assisting the mental health consumer to re-assimilate into their society. Most rehabilitation programs post incarceration are limited to simply linkages to temporary housing and focused on substance abuse. However, staff need to be trained to address consumers' recovery and re-integration into society through an understanding of the culturally based responses that our consumers have had to long term incarceration.

WORKSHOP 20

UNDERSTANDING AND REDUCING PROVIDERS' STIGMA RELATED TO SERIOUS MENTAL ILLNESS

Chairs: Patrick Corrigan, Psy.D., Dinesh Mittal, M.D.

Presenters: Tiffany Haynes, Ph.D., Greer Sullivan, M.D., Christina Reaves, M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Present the evidence that persons with serious mental illness receive poorer quality physical health care; 2) Describe a VA-funded study that examined how providers' (mental health and primary care) attitudes toward persons with serious mental illness influence clinical decision-making; 3) Describe development of a stigma reduction intervention tailored for providers.

SUMMARY:
Stigma about mental disorders is known to be widespread and to have devastating effects on the lives of those with mental disorders. Health care providers play a critical role in the lives and treatment of persons with serious mental illness (SMI). Individuals diagnosed with SMI are likely to receive sub-optimal medical, preventive, and specialty care, and mental health providers may be reluctant to refer persons with serious mental illness for rehabilitation services. Although we do not fully understand the reasons for these health-related disparities between individuals with and without SMI, it is likely that provider attitudes play a role. While there is some indication that general health providers and mental health providers exhibit negative attitudes towards persons with any mental illness, little is known about providers' stereotypes of persons with SMI.

Some studies suggest that, compared to the general public, mental health professionals have more negative stereotypes of those with mental illness, are more pessimistic about their SMI patients' chances of recovery, and have among the highest rates of stigmatization., By contrast, patient reports identify some primary care and general health providers as less sympathetic than psychiatrists towards patients diagnosed with mental illness. These contradictory reports highlight the need for more research. Little is known about differences in provider stigma by provider type (e.g., physicians or nurse practitioners) although these types clearly differ in other variables such as training, amount of contact, etc.

The goal of this project was to assess the influence of serious mental illness on providers' decision-making about treatment; and to compare the effect of mental illness on the decision-making of four different provider types (primary care physicians, primary care nurses, psychiatrists, and mental health nurses). We conducted a vignette based survey of psychologists, psychiatrists, nurses, and primary care physicians (N=351) at five VAMCs (and their affiliated CBOCs) to better understand attitudes, beliefs, and behaviors towards patients with SMI.

The symposium will include four presentations. The first presentation will describe existing and emerging research regarding beliefs and attitudes towards individuals with a serious mental illness that impact the quality of health care treatment they receive. The second presentation will describe the research methods and the findings of the study. The third presentation will detail the recruitment methods and data collection issues. The final presentation will describe the development of stigma reduction interventions tailored specifically for providers. The chair of the session will make the last presentation.

FRIDAY, OCTOBER 11, 2013

WORKSHOP 21

THE CALIFORNIA EXPERIENCE OF MENTAL HEALTH AND PRIMARY CARE INTEGRATION.

Chairs: Alvaro Camacho, M.D., M.P.H., Marshall E. Lewis, M.D.

Presenters: Marshall E. Lewis, M.D., Bernardo Ng MD, M.D., Roderick Shaner, M.D., Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify different barriers to implement the Integrated Care Model in different Counties throughout California; 2) Highlight the importance of including peers and family support to enhance the Integrated Care Model throughout different community clinics; 3) Illustrate the importance of a Culturally Tailored Integrated Care model delivered by community health workers to reduce depression; 4) Facilitate an open dialogue between practicing clinicians about their thoughts and experiences with the Integrated Care Model of Mental Health and Primary Care.

SUMMARY:
Since the introduction of the Wellstone-Domenici act in 2008 which provides parity medical benefits for Americans suffering from mental illness and substance use disorders, the health care system has been facing the new challenge of integrating non only behavioral health needs but the growing chronic physical and behavioral health problems that Americans have been facing. The California Psychiatric Association has voiced the need for legislators to address clear policy to improve and promote this integration, not only for parity care of mental illness but the crucial integration of mental illness with primary care services. Reports have voiced that most psychiatric problems present initially to the primary care provider. These conditions are frequently

misdiagnosed or not addressed appropriately due to lack of resources available to the general practitioner. Additionally, individuals with mental illness are at higher risk for developing cardiovascular disease, the leading cause of death among Americans. Most individuals with chronic mental illness have problems with access to care, poor support and poor compliance with treatment which in turn complicates the progression of their baseline mental and physical illnesses. Mental Health Systems are dealing with low income psychiatric patients defaulted into a managed physical health care with cap rates, therefore forcing counties to provide dual services under the new health plan. With this workshop we will outline and promote discussion on the following: Importance of involving peer and family support into the integration model and access to health care. (L.Marshall) Experience of the integration model in Geriatric Psychiatry (B.Ng) The integration model in Los Angeles County working with mental health services, managed care and cap rates (R.Shaner) The importance of delivering a culturally tailored Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model to improve depression in a border community clinic (A.Camacho) Discussion and future direction of the integration model and efforts of the APA to promote this model nationwide (L.Raney)

WORKSHOP 22

WHAT FAMILIES NEED FROM PSYCHIATRISTS

Chair: Lloyd I Sederer, M.D.

Presenter: Jay Neugeboren, M.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Depict critical role of family in ongoing care of people with serious mental illness; 2) Have families and consumers express what they need from psychiatrists in order to succeed as successful family supports; 3) Assist psychiatrists in working with families – despite concerns about privacy and patient preferences.

SUMMARY:
Families are the greatest asset a person with a mental illness can have. Yet they are often underutilized and sometimes sadly dismissed by the doctors who care for their loved ones. Issues such as privacy or meeting a patient's preferences are hailed as explanations for excluding families. At other times, psychiatrists have not been trained or developed skills to work with and support families as they support their loved ones.

This workshop will ask, and answer, what families want from psychiatrists – and how psychiatrists can do a better job of giving them what they need.

WORKSHOP 23

PSYCHIATRY IN THE STORM: ISSUES OF PUBLIC PSYCHIATRY DURING HOSPITAL EVACUATIONS

Chair: Wil C. Berry, M.D.

Presenters: Elizabeth Ford, M.D., Amit Rajparia, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Learn about practical and clinical issues that arise during the forced evacuation of a large public psychiatric hospital, using the 2012 evacuation of Bellevue Hospital as a case study; 2) Learn about issues of public psychiatry arising for special populations in such an evacuation, including patients in a forensic and emergency setting; 3) Learn about the legal and ethical issues of evacuation, including forced transfer of hospitals, evacuation against patient's will, use of renewed legal statues for involuntary admission prior to emergency transfer, and administration of medication against a patient's will for emergency transfer.

SUMMARY:
In the fall of 2012, Hurricane Sandy caused significant flooding to several major New York City hospitals, including NYU and Bellevue Hospital in Manhattan. This ultimately led to major losses in hospital faculties, including communications, power, and water supply. Bellevue Hospital, the largest public hospital in New York City with over 1000 patients and approximately 350 psychiatric inpatients, was dramatically affected. In the 72 hours following the storm, the hospital dealt with this emergency situation which culminated in a full evacuation. This evacuation, while a memorable and emotional experience for those who went through it, also represents a unique learning opportunity.

Such an evacuation provides a unique chance to examine issues of public psychiatry in emergency situations. This workshop will potentially focus on three areas. First, it will describe the experience of such an evacuation from a trainee perspective, described by a resident who was in the hospital for much of the process. Second, it will focus on clinical and systems issues which arise within a public psychiatric population, including questions of how to minimize disruption and trauma to a patient's treatment which has been interrupted by an emergent evacuation. Last, it will consider ethical and legal issues of evacuation, including issues of involuntary transfer, involuntary medication to assist in emergent transfer, and special consideration for forensic populations.

WORKSHOP 24

SHOW ME INNOVATION: MISSOURI'S HEALTH CARE HOMES INTEGRATE BEHAVIORAL HEALTH AND PRIMARY CARE

Chair: Jaron M. Asher, M.D.

Presenters: Caroline E Day, M.D., M.P.H., Joseph J. Parks, M.D., Sosunmolu O Shoyinka, M.D., Jaron M. Asher, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the benefits of Health Care Homes to patients; 2) Understand the policy implications of the Health Care Home model at the state level; 3) Identify the essential components of a curriculum teaching integrated care to psychiatry residents; 4) Recognize the benefits of implementing TEAMcare in collaborative practice.

SUMMARY:
In January 2012, Missouri was the first state to begin a Health Home program under Section 2703 of the Affordable Care Act (ACA). The Missouri Health Home program integrates behavioral health and primary care for two main reasons. First, this integration provides much needed access to care for underserved populations. Second, integrated care improves outcomes for both behavioral and physical health. TEAMcare, developed by Wayne Katon and others at University of Washington, is an integrated care model used as a tool in the Missouri Health Home. Compared with the usual care control group, patients with the TEAMcare intervention were significantly less depressed and also had improved levels of glycosylated hemoglobin, low-density lipoprotein (LDL) cholesterol, and systolic blood pressure. (Katon, NEJM, Dec 2010) Because the ACA promotes the expansion of the Health Home model, this workshop will share Missouri's experience from multiple perspectives. Dr. Joseph Parks, Medical Director of Missouri's Department of Mental Health, will highlight the development and preliminary outcomes of the Health Home program at the state level. Dr. Sosunmolu Shoyinka, Assistant Professor of Psychiatry at University of Missouri will present a model for training psychiatry residents in integrated care. Dr. Jaron Asher and Dr. Caroline Day are a psychiatrist and family medicine physician, respectively, who partner at both a Community Mental Health Center (Places for People) and a Community Health Center (Family Care Health Centers). Drs. Asher and Day will describe TEAMcare's implementation in the Health Homes in both settings.

WORKSHOP 25

PHYSICIAN SEXUAL MISCONDUCT

Chairs: Rahn k Bailey, M.D., William D Richie, M.D.

Presenters: Rahn k Bailey, M.D., C Freeman, M.B.A., M.D., William D Richie, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Educate and increase awareness of physician sexual misconduct and recognize signs of boundary crossings and violations; 2) Offer alternatives to objectionable behaviors, and if violation occurs, a range of treatment options available for both the patient and the offending physician; 3) Conduct a survey pre – and post-presentation to gauge the degree of awareness of PSM, risk factors amongst the participants, and whether education regarding PSM may prevent future PSM violations.

SUMMARY:
Physician sexual misconduct (PSM) is a form of behavior that adversely affects the public welfare. This behavior exploits the physician-patient relationship, violates the public trust and causes harm (both mentally and physically), to the patient. Physicians have an ethical code to abide by, and violation of this code almost always brings harm to patients resulting in a negative cascade effect for the individual patient, physician, professional institution or practice and the community. Physicians need be prepared to encounter forward or provocative patients who overstep their bounds past a professional relationship; however it is always the physician's responsibility to maintain appropriate boundaries. Regardless of whether sexual misconduct is the result of an underlying psychiatric illness such as addiction disorder, mental disorder, sexual disorder or phase of life crisis, licensing boards are delegated the responsibility to protect the public. Studies show that between 3-10% of physicians commit boundary violations, but research varies by methodology, operational definitions, and sampling selections, and it is generally accepted that such behaviors are grossly underreported. Among the different medical specialties, psychiatry has the highest risk of violating professional boundaries followed by family medicine and obstetrics and gynecology. The rationale of the pilot study is to gauge the degree of awareness of PSM and alert the participants to potential risk factors. We hypothesize that educational intervention regarding PSM may prevent future PSM violations, and theorize that such interventions need be conducted throughout the clinician's career to update and refresh the clinician on this important topic. The primary objective of this review is to educate and increase awareness of physician sexual misconduct and recognize signs of boundary crossings and violations. The secondary objective is to offer alternatives to objectionable behaviors, and if violation occurs, a range of treatment options available for both the patient and the offending physician. The tertiary objective is to conduct a survey pre – and post-presentation to gauge the degree of awareness of PSM, risk factors amongst the participants, and whether education regarding PSM may prevent future PSM violations.

WORKSHOP 26

GROWING A GENERATION OF RECOVERY-ORIENTED PSYCHIATRISTS BY TEACHING AND MODELING MOTIVATIONAL INTERVIEWING AS OUR FUNDAMENTAL COMMUNICATION STYLE

Chair: Michael A. Flaum, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Discuss what is meant by the terms "mental health recovery" and "recovery-oriented outcomes"; 2) Identify and discuss the four components of the spirit of motivational interviewing and their relationship to recovery oriented practice; 3) Identify and discuss the four processes of motivational interviewing and their relationship to recovery-oriented practice; 4) Know how to access web-based resources on motivational interviewing and understand the recommended approaches to training in MI.

SUMMARY:
Over the past two decades, many have called for a paradigm shift in which all providers of mental health services, including psychiatrists, view the "promotion of recovery" as the primary outcome they should be striving to achieve. What does this actually look like in the real world and how can we prepare psychiatric trainees to be more likely to practice in a recovery-oriented manner? This workshop will suggest that teaching and modeling Motivational Interviewing (MI) as a fundamental style of communication throughout psychiatric training may go a long way towards building a generation of recovery-oriented psychiatrists. It will introduce those unfamiliar with MI to its 4 interwoven processes, and demonstrate how its underlying spirit relates to recovery.

WORKSHOP 27

FROM REFLECTION TO REFLEX: MAKING ETHICAL DECISIONS IN REAL TIME IN THE PSYCHIATRIC EMERGENCY SERVICE

Chairs: John S. Rozel, M.D.; Alin J Severance, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the challenges of using traditional medical ethics approaches in time sensitive settings like the Psychiatric Emergency Service; 2) Understand the conflict between the autonomy-centered values of the recovery model and the historic and traditional paternalistic model of American psychiatry; 3) Learn to distinguish ethical dilemmas that are easily reconcilable, solvable with effort, or insoluble; 4) Join a discussion about how to recognize and rapidly navigate ethical challenges in emergency and acute care settings .

SUMMARY:
Emergency psychiatry often requires quick decisions: should restraints be used? Should PRN medications be given and if so, which? How dangerous does a person need to be to justify involuntary admission, especially if such treatment may alienate that person from seeking mental health services in the future? How dangerous does a threat need to be to justify breaching confidentiality? Should a parent who appears impaired or intoxicated really make decisions for their child? Making challenging ethical decisions quickly, consistently and correctly is a great challenge for front line clinicians. Traditional academic approaches to medical ethics may not offer timely or satisfactory resolution of these problems; decisions often need to be made in seconds or minutes and cannot wait until the next day for an ethics consult or second opinion. The language of medical ethics does not always lend itself to practical decision making; poststructuralist and feminist ethical theory may well have illuminating perspectives on power and coercion, but this does little to aid the nurse deciding when to release a person from restraints. Clinicians, especially in high acuity settings like the emergency department, need a framework for rapid, practical ethical problem solving.

Most medical ethics questions are actually easily resolved, often without even conscious awareness that one is making an ethical decision; for example, a patient offers cash for an alprazolam prescription and the physician appropriately declines. Some ethical questions may be insoluble or leave even the most astute ethics consultant unable to offer more than a choice of less than desirable options. The clinician's challenge is to recognize and thoughtfully manage the potentially soluble situations in a timely manner and, perhaps, to recognize and accept that some will remain insoluble.

The discussion leaders both work predominately in a crisis center providing direct care and supervising multidisciplinary teams; one has a background in the philosophy of science, one has a background in biomedical ethics. They will briefly review some of the broad frameworks of psychiatric ethics and ethical problem solving and the implications of transitioning from a paternalistic medical tradition to a recovery model. They will lead a discussion of different approaches to rapidly resolve challenging issues, and, when possible, attempt to identify solutions that are most congruent with the recovery model.

WORKSHOP 28

THE LIMITS OF CURRENT HEALTH REFORM FOR PSYCHIATRY

Chairs: Leslie H. Gise, M.D., Steven S. Sharfstein, M.D., M.P.H.

Presenters: Ole Thienhaus, M.B.A., M.D., Leslie H. Gise, M.D., Alice H. Silverman, M.D., Steven S. Sharfstein, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the barriers to universal health coverage and their impact on the mental health delivery system; 2) Recognize how our 2010 law with enhanced managed care may drive psychiatrists out of the treatment system; 3) Understand that without true system reform, individuals with serious mental illness will continue to end up in prisons or homeless; 4) Articulate more effective solutions to our access, quality and cost issues.

SUMMARY:
Full implementation of the Affordable Care Act moves us closer to the goal of universal health coverage but continues to exclude many; it is estimated that 30 million Americans still will not have public or private coverage. Since many of the uninsured suffer with psychiatric diagnoses, this uncompensated care burden falls disproportionately on the mental health system, especially for psychiatric care of the seriously ill. Our 2010 health care reform law promises full parity of care for mental health and substance use disorders with general medical services, but at what cost? Enhanced managed care utilization review and intrusion into medical care may drive many practitioners, particularly psychiatrists, out of the treatment system. The implementation of insurance exchanges and the expansion of Medicaid will be uneven across and within many states. As a result, there will be no true system reform (especially for mental health care) and individuals with serious mental illness will continue to fall through the cracks, ending up incarcerated in prisons or homeless on the streets. Better solutions to the access and quality issues are apparent but lack of political will hinders their implementation. These include expansion of Medicare to all and the adoption of integrated systems of care such as the Veterans Administration. There also remains a strong ethical argument for single payer. This workshop will review the current status of health reform in America with a perspective of single-payer advocacy as we move as a system from volume to value with incremental improvements in access to care and little effort to truly bend the cost curve. APA has position statements supporting universal health care (2004), universal access to psychiatric care (2008) and the Assembly passed an action paper (2011) "health care is a right". The American Psychiatric Association should lead the way and support single payer health care reform.

WORKSHOP 29

DOES ONE SIZE FIT ALL? THREE PSYCHIATRIC HEALTH HOME MODELS, THEIR PATIENTS, AND THE RESIDENTS WHO WORK IN THEM

Chairs: Tauheed Zaman, M.D., Elizabeth A Horstmann, M.D.

Presenter: Lesha D. Shah, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Define three models of integrated health homes and describe their characteristics; 2) Identify sub-populations of psychiatric and medical patients often served by these models; 3) Discuss pros and cons of training residents within each health home model.

SUMMARY:
As psychiatry moves towards different models of integration with primary care, psychiatry residencies have broadened training experiences to reflect these evolving models of care. This workshop will focus on three resident experiences within different models of care integration (forward co-location, reverse co-location and true co-location) in three different geographic areas (western Massachusetts, Boston, and NYC). We will present a clinical vignette to illustrate each approach and the outcome measures used in each venue. We will discuss the sub-populations among psychiatric/medical patients that may benefit from each model of care, and the impact on resident education of training within each system.

Forward co-location model – children's mental health consultation in the primary care setting:

At the Baystate Medical Center in Springfield, MA, residents participate in the Massachusetts Child Psychiatry Access Project (MCPAP): a unique system of regional consultation teams designed to help primary care providers meet the needs of children with psychiatric problems. This forward co-location model, open to the 1.5 million children of Massachusetts, aims to reduce emotional and behavioral impairments among children. Residents gain experience in providing psychiatric consultation, direct services, care coordination, and education among a pediatric population.

Reverse co-location model – an internist comes to the severely and persistently mentally ill:

At the Columbia University Medical Center in New York City, residents care for a severely and persistently mentally ill (SPMI) population in a reverse co-location model where an internist comes into two state-run mental health clinics and provides consultation on medical issues identified by psychiatrists. Residents gain experience in conducting regular screenings for cardiovascular disease and metabolic syndrome among other medical illnesses, alongside routine psychiatric care.

True co-location model – an integrated HIV-psychiatry clinic:

At the Cambridge Health Alliance in Cambridge, MA, the Zinberg clinic takes a multidisciplinary approach to the care of patients living with HIV/AIDS. Residents serve within this model of true co-location as a liaison between psychiatrists, internists, nurse practitioners, psychologists and social workers. Daily integrated team meetings, along with the chance to follow cases longitudinally, allow residents to gain facility in treating medical, psychiatric and substance-related co-morbidity within an often complex social context.

WORKSHOP 30

NO EASY WALK TO FREEDOM: ACCOMPANYING LONGTERMERS IN THEIR JOURNEY TOWARD PAROLE

Chairs: Carol L Kessler, M.D., Kathy Boudin, Ed.D., M.Sc.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize the elements of the "longtermers' project" that empower individuals who have been incarcerated for a homicide-related offense to find their voice and to accept responsibility for their crime; 2) Understand the concept of restorative justice; 3) Identify the obstacles that longtermers face as they prepare to meet the parole board. .

SUMMARY:
The Longtermers' Project is an innovative project that has been sponsored by the Osborne Association, a nonprofit organization offering programs to incarcerated/ paroled people in NY and their families. This project is rooted in the principles of restorative justice and enables people who have been in prison for decades due to a homicide-related offense the hope of moving from trauma/ guilt/ shame/ silence toward a narrative wherein they take responsibility for their crime. Volunteers are trained by individuals who have completed this transformative process as well as by therapists rooted in the restorative justice model; once trained, volunteer therapists enter prison and accompany individuals preparing to face the parole board. A curriculum has also been developed and implemented with groups in Sing Sing, Fishkill, and Bayview Correctional Facilities to assist individuals who have been incarcerated for decades to integrate concepts of responsibility and amends into their life story. Dialogue, journal-writing, remembrance of the victim, and recall of the traumatic moment of the crime with simultaneous hope for transformation and amends is a powerful, transformative process that awakens freedom regardless of the outcome before the parole board.

WORKSHOP 31

RECOVERY THROUGH THE CONTINUUM OF CARE: A LOOK AT PRE-HOSPITAL, HOSPITAL, AND OUTPATIENT RECOVERY-BASED INTERVENTIONS

Chairs: Rowena Cabigon Mercado, M.D., M.P.H., Ana T. Turner, M.D.

Presenters: Ana T. Turner, M.D., Anthony S. Battista, M.D., M.P.H., Rowena Cabigon Mercado, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Define the fundamental elements of recovery, and review ways to incorporate recovery principles into existing systems of care; 2) Identify recovery-oriented interventions and best practices in mental health care, spanning pre-hospital crisis intervention, inpatient hospitalization and outpatient care; 3) Discuss potential innovations and adaptations to current recovery-based services and interventions that will improve accessibility and quality of care.

SUMMARY:
Clients served by mental health systems often require personalized interventions depending on the phase and severity of a particular illness episode. With the help of the recovery movement, systems are working to meet the needs of clients in helping them reach goals in ways that foster hope, self-efficacy, empowerment, social integration, and respect. To provide context for the discussion, we will briefly review the fundamental elements of recovery, and identify ways to incorporate recovery principles into existing systems of care.

Most of the workshop will focus on how recovery can be promoted throughout the continuum of care. Currently, crisis intervention care is often limited to psychiatric emergency services and inpatient hospitalization. Expanding the options and modalities of crisis intervention could serve the interests of clients, families, providers, and the community-at-large in terms of effectiveness, adherence to recovery principles, and cost. We will discuss one option of expanded services, the crisis residential facility, as a means of maximizing recovery in crisis. Once on the inpatient unit, there are several opportunities for care providers to facilitate recovery. We will identify a process for including the voices and experiences of recovering individuals as well as care providers, and obtaining continual client and provider feedback in creating a recovery-oriented group environment. We will also discuss the usefulness of research-based, outcome-driven handbooks, skills training group therapy, and staff education on a recovery-oriented process for one VA inpatient psychiatric hospital. In the outpatient setting, several recovery-based interventions have been developed and adapted over the years. In this workshop, we will examine interventions that may be considered by recovery-oriented experts as best practice, most innovative or evidence-based. We will also discuss potential adaptations to existing recovery-based services that may promote more widespread uptake of these interventions, especially in the context of changes being made in light of the move for integration.

WORKSHOP 32

BEYOND CULTURAL COMPETENCY: ENGAGING TRAINEES IN CRITICAL THINKING ABOUT CULTURE, SOCIAL JUSTICE, AND MENTAL HEALTH

Chairs: Ippolytos A. Kalofonos, M.D., Ph.D., Courtney L. McMickens, M.D., M.P.H.

Presenters: Elizabeth Bromley, M.D., Ph.D., Helena B. Hansen, M.D., Ph.D., Jonathan W. Metzl, M.D., Ph.D., Ye Beverly Du, M.D., M.P.H., Sarah A Bougary, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Explore how residents and faculty are developing innovative approaches to generating discussions about social justice and mental health both within and outside of formal residency curriculum; 2) Encourage a dialogue amongst panelists and participants regarding approaches that are currently being implemented; 3) Broaden the scope of the discussion regarding social and cultural competencies in psychiatric training; 4) Incorporate perspectives from history and the social sciences into psychiatry training programs.

SUMMARY:
Psychiatry has always been a vanguard within medicine in highlighting the importance of the intersection of culture and health (Kleinman 1977). Cultural competency is today a staple of medical education, as mandated by the Liaison Committee on Medical Education. Critiques of cultural competency, however, argue that standard approaches do not appreciate medicine itself is a cultural system, thus reinforcing hierarchies of knowledge systems (Taylor 2003), and that attention to culture does not necessarily lead to an awareness of the social justice issues that are frequently integral to health disparities (Kumagai and Lypson 2009).

This workshop presents perspectives from residents and faculty who are attempting to address these dynamics within their own training programs. Taking cultural competency as a starting point, a panel of residents will present their own experiences developing initiatives aimed at increasing critical discussion of issues of culture, inequality, and mental health within their own training programs through the use of traditional didactics, media and technology. This will be followed by a panel of faculty who will present approaches that teach critical thinking skills by emphasizing the historical and sociocultural circumstances that shape psychiatry (Bromley and Braslow 2008) and a complementary paradigm to cultural competency, that aims to directly account for the roots of social inequality, termed structural competency (Metzl, 2012).

The goal is to broaden the scope of the discussion regarding social and cultural competencies in psychiatric training and incorporate perspectives from history and the social sciences.

1. Kleinman, Arthur. 1977 Depression, Somatization, and the "New Cross-cultural Psychiatry." Social Science & Medicine 11(1) 3-10.

2. Taylor, Janelle. 2003. Confronting Culture in Medicine's Culture of No Culture. Academic Medicine, 78 (6): 555-559.

3. Kumagai, Arno and Monica Lypson. 2009. Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education. Academic Medicine 84 (6): 782-787.

4. Bromley, Elizabeth and Joel Braslow. 2008. Teaching Critical Thinking in Psychiatric Training: A Role for the Social Sciences. American Journal of Psychiatry 165: 1396-1401

5. Metzl, Jonathan. 2012. Structural Competency. American Quarterly, 64(2): 213-218.

WORKSHOP 33

PLANNING BEYOND SURVIVAL: PROVIDING PSYCHIATRIC SERVICES FOLLOWING A DISASTER (LESSONS FROM SURVIVING SANDY IN LONG ISLAND)

Chairs: Nyapati R. Rao, M.D., M.S., Damir Huremovic, M.D., M.P.P.

Presenters: Lisa Jacobson, , Rajvee Vora, M.D., M.S., Constantine I. Ioannou, M.D., Jacob E. Sperber, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the challenges mental health agencies faced during preparation and in the aftermath of a major hurricane-force storm in NY; 2) Understand how to identify and utilize the local and federal resources available to health providers following a major disaster; 3) Understand the need for coordinated response planning to ensure adequate mental health care services after a disaster; 4) Develop strategies for a coordinated mental health care response planning in a disaster affected area.

SUMMARY:
Unlike some natural disasters (e.g. earthquakes), hurricane-force storms have a unique feature of being forecast, giving the communities in their path some time to prepare. During this little lead time, that often barely allows only for evacuation, mental health care agencies and providers must make difficult professional and personal choices about how to weather the storm and how to continue to operate and

provide services in its aftermath.

Contingency plans for such events mostly deal with preserving assets for continued and uninterrupted provision of services. Most of such plans also contain provisions for addressing a spike in disaster-related emotional distress in the population. What is often overlooked when preparing for such events, however, is that storms of such magnitude change the landscape of the mental health services as much as they change the physical landscape of the affected area.

Having survived the storm, mental health agencies and providers find themselves multitasking at different levels: providing for own inpatients while caring for patients evacuated from other facilities, reconnecting with own outpatients while attending to never-before-seen patients who now cannot reach their own providers, coordinating assistance with local, state, and federal disaster management agencies while personnel's own homes are in dark, flooded, or completely destroyed.

A remarkable part of recovery after a major disaster is the task of re-mapping and reestablishing the fabric of community mental health services, a challenge that cannot be addressed by a single agency or provider. A portion of precious time communities have to prepare for an impact of a major storm that is spent on coordinating care can be leveraged enormously in the aftermath of the disaster.

This workshop reviews the challenges and adversities that a pivotal Long Island mental health facility – Nassau University Medical Center, faced during Sandy, a hurricane-force storm affecting the metro NYC area in the Fall of 2012. Leadership of the Department of Psychiatry provides a personal account of own experiences as well as analysis of what was done well through preparations and in the aftermath and what could have been done better. A special consideration will be given to the aspect of coordinating response with and relying on assistance from local, state, and federal agencies (e.g. FEMA, PHS, and Disaster Area Management Teams).

Ample time will be allowed for questions and answers and for interaction with participants.

WORKSHOP 34

ASK THE EXPERTS, AN INSIDER'S PERSPECTIVE: A CONVERSATION WITH PEER COUNSELORS ACROSS SERVICES AND THE LIFESPAN

Chair: Joseph P. Merlino, M.D., M.P.A.

Presenters: David Genna, Steven Nager, B.A., Wilma O'Quinn, Graylin Riley, Marion Thomas

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize the value of the role of the peer counselor as a member of the interdisciplinary treatment team in fostering a recovery oriented, patient-centered model of care; 2) Appreciate the struggle peer counselors face in balancing their roles as patient advocates and treatment team members; 3) Recognize the importance of peer counselors' experiences throughout the significant developmental stages of their lives and its impact on their work.

SUMMARY:
The employment of peer counselors is a critical component in the development and application of a patient-centered, recovery model of care. As "ambassadors of empathy" they approach the care of the patient from an insider's perspective. They represent hope, healing, and peer support, some of the main tenants of the recovery model. They are living proof that recovery is not only possible, but that recovery does happen! Peer counselors are able to liaison for the patient with the treatment team as they utilize their personal experiences to inform the treatment approach. The employment of peer counselors facilitates the establishment of a recovery philosophy of care in an organization, as it supports the personal recovery of these employees as well as the transformation of the organization. Kings County Hospital Center (KCHC) has developed the largest peer counselor program in the country and has peers embedded throughout the service in the Comprehensive Psychiatric Emergency Program (CPEP), the outpatient clinic, The Partial Hospitalization Program (PHP), adult inpatient service, and the Behavioral Health primary medical clinic. In other words, they have vast experience and much to teach. KCHC's Peer Counseling Program has been a model internationally for organizations looking to develop such programs. In a highly interactive format this workshop will provide the opportunity to learn from peer counselors themselves about their role and impact as integral members of the interdisciplinary treatment teams. Life and wellness are ongoing. You will also get a chance to hear about the challenges of balancing the demands of the job and self-wellness.

WORKSHOP 35

BIOPSYCHOSOCIAL OR BUST

Chairs: Mark Opler, M.P.H., Ph.D., Lewis A. Opler, M.D., Ph.D.

Presenters: Ernest J. Millman, M.P.H., Ph.D., Michael A. Schwartz, M.D., Lewis A. Opler, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Learn the importance of representative surveys of defined general adult populations; and how Dr. S. Michael, furthered Dr. Rennie's goals, which helped to modernize psychiatry; 2) Learn to differentiate reductionistic, method-based, biopsychosocial & person/people centered psychiatry; 3) Understand how measurement in psychiatric and community research can and should take culture and language into account.

SUMMARY:
The past century of research and practice in psychiatry has been one of extremes, as one ideological position after another dominated the field: psychoanalytic, genetic, institutionally-oriented, community-oriented hegemonies ruled and then faded. Each perspective tended towards reductionism, whether biological or social, nature or nurture, pharmacology or psychology; unfortunately such reductionism narrowed the focus of research, policy, and patient care at many levels of organization. Nonetheless, throughout the last century there has always been a small but vocal minority in favor of holistic, multi-polar/multi-disciplinary approaches to mental health. Beginning with the findings of the Midtown Manhattan Study through the "person-centered" medicine of the present day, the ascendance of a broader, more humanistic and also more evidence-based approach to treatment may be at hand. This symposium will review the history, research, and practice of holistic approaches, examining the role of culture and context in their emergence and characteristic viewpoints. The session will be highly interactive, including discussions between presenters from various orientations and opportunities for audience commentary and participation.

WORKSHOP 36

ON THE STREETS OF CLEVELAND: A NOVEL APPROACH TO COMMUNITY PSYCHIATRY

Chair: Archana D. Brojmohun, M.D.

Presenters: Archana D. Brojmohun, M.D., Sally Moennich, B.S.N., M.B.A., Patrick S. Runnels, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Reflect on the role of a novel elective option in the development of the resident as a community psychiatrist; 2) Recognize the contribution of the resident to the community through those experiences; 3) Exemplify that there are other community psychiatry options that can be developed for better patient care as well as better resident exposure to community psychiatry.

SUMMARY:
The authors present two parts of an elective developed specifically for fourth year psychiatry residents in training. The first one involves the delivery of patient care by residents in the patient's home in collaboration visiting nurses from the Visiting Nurses Association of Ohio free of charge for the patients. The patient population targeted was those patients who were discharged from the emergency department or the inpatient psychiatric unit. The team consisting of a resident and nurse provided care during the interval of time from discharge to linkage to a community mental health center.

The second part of the elective consists of joining a homeless outreach team to outreach the homeless mentally in shelters and various parts of the city and offer mental health services, medications as well as linkage to a community mental health center and/or substance abuse program.

WORKSHOP 37

EXPANDING THE REACH OF RECOVERY-ORIENTED CARE

Chair: Paul J. Rosenfield, M.D.

Presenters: Lisa Caren Litt, Ph.D., Paul J. Rosenfield, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify the components of recovery-oriented care in general; 2) Define the concept of recovery-oriented care for a clinic population with depressive, anxiety, post-traumatic, and personality disorders, not traditionally considered "serious mental illness"; 3) Consider the role of trauma in formulating a concept of recovery-oriented care for a general clinic population; 4) Apply this concept to specific examples of care.

SUMMARY:
The literature on recovery and recovery-oriented care originates in and focuses on the population with serious mental illnesses (SMI) such as schizophrenia. Studies on outcome for individuals with schizophrenia, autobiographical accounts of recovery, consumer activism and advocacy, effective treatments, and a reorientation toward engaging in the world rather than being protected from relapse have made the concept of recovery for SMI an achievable goal. The options of supported employment and housing for SMI, dual diagnosis treatment, integrated medical care, inclusion of peers with SMI in the workforce – all these have helped to empower individuals with SMI and address the real life issues they face.

Epidemiological data show that 50% of the population experience mental illness at some point in their life time, and the majority have depressive, anxiety, PTSD, adjustment, addictive, and personality disorders. Individuals with these disorders also experience stigma, functional impairment and disability, high rates of trauma, worse medical health and higher mortality, high rates of substance abuse, and more. What kind of recovery-oriented care is available for

them, and what else should be put in place?

We propose to define recovery-oriented care for the broader range of individuals seeking psychiatric care. Several essential categories will be addressed and defined as they refer to the non-SMI population:

- Welcoming environment and recovery orientation
- Strengths-based assessments, person centered treatment planning, shared decision-making
- Trauma assessment and trauma-informed treatment
- Substance assessment and integrated substance treatment
- Medical assessment and integrated medical treatment
- Vocational and educational goals
- Peer engagement

Presenters will describe the various services in the outpatient division at St Luke's Roosevelt Hospital in New York and the ways in which they have attempted to develop their recovery orientation with regard to these aspects. They will focus particularly on the role of trauma and the importance of creating a safe space for growth as a condition for recovery-oriented care. Paul Rosenfield, MD, is Director of the Outpatient Psychiatry Clinic OPC) at St Luke's Roosevelt Hospital; Lisa Litt, PhD, is the Director of the Women's Health Project and Men's Center for Healing and Recovery at St Luke's Roosevelt, and Jeanne Cummings, DNS, PhD, is a psychiatric nurse practitioner in the OPC [this presenter to be added to submission at later date due to personal circumstance precluding her ability to complete participant disclosures].

WORKSHOP 38

SMART PHONES IN THE CLUBHOUSE: AN EXPLORATION INTO THE INFLUENCES OF MOBILE TECHNOLOGY ON PSYCHOSIS, THE THERAPEUTIC ALLIANCE, AND RECOVERY

Chair: Neisha D'Souza, M.D.

Presenters: Neisha D'Souza, M.D., Neil A. Falk, M.D., Daniel Towns, D.O.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize the social impact of mobile technology within our lives and the lives of consumers; 2) Identify complexities that may arise for consumers with psychotic symptoms as they utilize mobile devices; 3) Identify potential opportunities in which mobile technologies may be utilized to enhance recovery.

SUMMARY:
Our world is changing. With the emergence of mobile technology, the way we interact with and perceive one another has become increasingly complicated. This presents particular challenges, and perhaps opportunities, within severely mentally ill populations. Just as community and culture have always informed mental illness, evolving and ever-present technologies likewise update how people with psychotic disorders interact with their world and treatment providers. In this workshop, we hope to contemplate recent trends in the interface of pocket technology and psychosis and what this portends for future recovery-oriented treatment of this population.

WORKSHOP 39

TRANSFORMING FOOD CHOICES AT COMMUNITY MENTAL HEALTH CENTERS

Chair: Michael J. Sernyak, M.D.

Presenters: Robert A Cole, Marydale Debor JD, J.D., Kyle Pedersen,

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the relationship of "nutrition status" to mental and physical health and the current barriers presented by food service operations to promoting human health; 2) Understand the structure of the institutional food service transformation plan and its step-wise implementation in the CMHC initiative; 3) Gain insight into the positive therapeutic role that a healthful food service operation can play in community mental health practice and research, without increasing costs.

SUMMARY:
Chronic illnesses such as obesity, diabetes and CVD are a serious challenge in public mental health practice. Comorbidity from physical illness can be reduced by changes in the environment of care, most notably by integrating food and nutrition into the overall therapeutic approach. Community mental health centers have an opportunity to improve patient outcomes by re-inventing what and how we feed the patients and communities served. In this workshop we present the experience of the Connecticut Mental Health Center in developing a food policy, hosting a farmers' market, building an edible garden and redesigning the food service for employees, patients and visitors. We will provide an opportunity to discuss challenges in reforming institutional food service as a part of health care practice and research.

WORKSHOP 40

ACT (IN) FIDELITY

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

Presenters: Theodora G. Balis, M.D., David C. Lindy, M.D., Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the DACT and TMACT models of ACT fidelity; 2) Discuss approaches to Assertive Community Treatment in at least two different systems; 3) Identify systems issues which make full adherence to ACT fidelity models a challenge.

SUMMARY:
Assertive Community Treatment (ACT) began in Madison Wisconsin in the early substantial as a way to provide hospital-like services to help people with serious mental illness and multiple hospitalizations to remain in the community. Over time ACT was evaluated in various settings and with various populations (VA, rural, homeless) and was generally found to reduce hospital days and improve quality of life measures. Over the past several decades there have been several models of Assertive Community Treatment and two important tools for assessment of ACT fidelity: the Dartmouth ACT Fidelity Scales (DACTS) and the Tool for Measuring fidelity to Assertive Community Treatment (TMACT). However practicing the ACT in the community is complicated by various system pressures and requirements.

In this workshop, we will describe challenges to providing high quality ACT services faced in two different systems. The first of these programs is in Maryland (at a University of Maryland based urban ACT team originally started to provide ACT services for homeless individuals) where funding for ACT is based on state interpretation of fidelity to an ACT model; the second is in New York City where state expectations, limited psychiatrist time and inability to choose or decline ACT consumers makes it difficult to provide high quality ACT services.

In this workshop we will invite participants to report their own experiences and challenges in the provision of ACT treatment. And with our audience we will work to consider ways to continue to provide quality ACT services and recovery oriented, person-centered treatment within the requirement and expectations of our particular programs and systems.

SATURDAY, OCTOBER 12, 2013

WORKSHOP 41

ELECTRONIC HEALTH RECORDS: WHAT PSYCHIATRISTS NEED TO KNOW

Chair: Robert M Plovnick, M.D., M.S.

Presenters: Daniel J Balog, M.D., Laura J. Fochtmann, M.D., Lori Simon, M.D., Zebulon C. Taintor, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify common questions and issues faced by psychiatrists considering the adoption of Electronic Health Records, (e.g., selection, implementation, and use); 2) Learn from challenges faced and lessons learned from psychiatrists who have adopted an Electronic Health Record; 3) Provide actionable details on national activity in EHRs, including the Medicare/Medicaid EHR Incentive program.

SUMMARY:
Electronic Health Records (EHRs) have been touted for their potential to improve documentation and communication to impact quality, but have also raised numerous concerns regarding their cost, complexity, and privacy limitations. Physicians who treat Medicaid or Medicare patients and demonstrate "meaningful use" of electronic health records are eligible for significant financial incentives. Starting in 2015, Medicare reimbursement rates will be reduced for physicians who do not meet this requirement. The momentum for the increased use of EHRs in Medicine continues to build. This workshop, sponsored by the APA's Committee on Electronic Health Records, will present and expand on various aspects of EHRs and Health Information Technology that have been discussed in a series of columns in Psychiatric News over the past year (e.g. the Medicare incentive program and "Meaningful Use," psychiatrist experiences implementing EHRs, and EHR features and functions that are important to psychiatric practice). The workshop will conclude with ample time for attendees to pose questions to members of the Committee.

WORKSHOP 42

RECOVERY-ORIENTED COGNITIVE GROUP THERAPY FOR SCHIZOPHRENIA: EMPLOYING POSITIVE ACTION TO REMOVE ROADBLOCKS TO RECOVERY

Chair: Aaron T. Beck, M.D.

Presenters: Paul M Grant, Ph.D., Aaron Brinen, Psy.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify techniques to engage group members and raise their energy level; 2) Name 3 group process factors used during CT-R group therapy; 3) Describe a simple technique that can be added to an existing group to make it a CT-R group.

SUMMARY:
We will present a unique application of group therapy to promote recovery for individuals with persistent schizophrenia. Recovery-Oriented Cognitive Group Therapy (CT-R) is organized around increasing positive action levels, removing obstacles to activity (e.g. voices, anger, dysfunctional beliefs), and ultimately helping each individual achieve meaningful goals that they have identified. In hands-on demonstrations and discussion, we will outline how to use the group process to engage each individual in their own psychiatric rehabilitation, correct inaccurate or unhelpful beliefs that are roadblocks to recovery, and to help group members get back to life. We will address common obstacles encountered during group therapy, approaches to modifying current group practices to increase impact, and balancing group process and individual formulation. We will also discuss modifications for inpatient and outpatient groups. We will provide program evaluation data and clinical anecdotes to buttress the key take home points.

WORKSHOP 43

COMMUNITY ENGAGEMENT AND RECOVERY AS ORGANIZING PRINCIPLES FOR COMMUNITY PSYCHIATRY EDUCATION

Chair: Robert S. Marin, M.D.

Presenter: Wesley E. Sowers, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the relationship between recovery processes and community living; 2) Describe approaches to integrating recovery processes and community engagement with fellowship training in public and community psychiatry; 3) Describe a content curriculum and a teaching process that focus on engaging service users and behavioral health providers as faculty; 4) Present evaluation data that describe the experience of the community engaged faculty composed of service users and behavioral health providers.

SUMMARY:
Transforming the mental health system into a recovery oriented, integrated system of care requires a psychiatric work force that understands the relationship between recovery processes and community living. Fellowship programs in public and community psychiatry contribute to this transformation by educating psychiatrists about recovery, system dynamics, leadership, effective administration and community involvement. This paper describes a novel approach to fellowship programming that accomplishes these aims through an organizational strategy that emphasizes community engagement. After describing the administrative background for the program, we describe how the content curriculum and teaching process focus on the engagement of community members – both service users and service providers – as participating faculty. The faculty includes over 100 consumers, family members, advocacy group representatives, clinicians, and administrators. We present evaluation data obtained from 45 of the 100 community and university faculty who participated in the first 2 years' of the fellowship and conclude with a critique and recommendations for further progress in community engaged fellowship training.

WORKSHOP 44

SPIRITUALITY, RELIGION AND PSYCHIATRY: EDUCATIONAL CHALLENGES AND OPPORTUNITIES

Chair: John R. Peteet, M.D.

Presenters: Michael A. Norko, M.D., Wai Lun Alan Fung, M.D., S.M., Theresa A. Yuschok, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify learning needs of psychiatric residents in the area of spirituality and religion; 2) Recognize major challenges to teaching and learning about spirituality/religion in psychiatry; 3) Identify effective educational interventions and the reasons for their effectiveness.

SUMMARY:
Despite remaining tensions and misunderstanding between psychiatry and religion, interest continues to grow in the role of spirituality and mental health treatment. Examples include Twelve Step spirituality, mindfulness, and spiritual care at the end of life. While the Joint Commission mandates spiritual assessments and the ACGME requires training in this area, significant educational challenges remain, such as engaging skeptical residents, identifying credible faculty, and effectively integrating with the rest of the curriculum. After hearing brief presentations of educational initiatives at four institutions (Harvard Longwood, Yale, Duke and the University of Toronto), participants will discuss what approaches have proven most effective in dealing with key challenges and why, with a view to how these can be adapted to the specific needs of learning audiences.

WORKSHOP 45

BOUNDARIES IN CLINICAL PRACTICE AND IN TRAINING: REDUCING RISK FOR PRACTITIONERS AND PATIENTS

Chair: John S. Martin-Joy, M.D.

Presenters: Thomas G. Gutheil, M.D., Caleb Korngold, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify boundary issues commonly encountered in the clinical practice of psychiatry and psychotherapy and during professional training; 2) Differentiate between boundary crossings and boundary violations; 3) Describe the role of context in evaluating boundary issues; 4) Describe effective strategies for risk reduction, such as consultation, supervision, and documentation.

SUMMARY:
Professional boundaries are critical to patient safety, yet can be elusive for the mental health practitioner. When a patient asks for personal information about a therapist, when a client presents a psychiatrist with a gift, or when a treater has sexual feelings for a client, what is the appropriate response? Clinicians may be unsure of the rules, anxious about malpractice suits, and hesitant to upset their patients. As a result, clinicians may keep silent or resort to elaborate defensive practices. These issues may be especially pronounced for a practitioner in training.

This workshop will explore key issues associated with boundaries in clinical practice. First, we will identify common boundary issues as they occur in mental health practice. Second, we will help clinicians develop a way of thinking through such dilemmas by integrating sound clinical care with risk management. Finally, we will identify practical ways for clinicians to reduce their own risk by maintaining appropriate boundaries.

Throughout, we will differentiate between boundary crossings (nonharmful departures from a clinician's usual role, often minor and undertaken in the interest of supporting the treatment) and boundary violations (harmful departures from a clinician's usual role, typically not undertaken in the patient's best interest). Core principles, derived from Gutheil and Gabbard's "The Concept of Boundaries in Clinical Practice" (Am J Psychiatry 1993), will include the importance of context in evaluating boundary issues; the usefulness of clinical exploration in reducing harm; and the role of consultation and documentation in reducing risk. Extensive audience participation will be encouraged.

John Martin-Joy, M.D., will introduce the topic and the presenters. He will present empirical data on medical-legal risks for mental health practitioners, including malpractice claims, board of registration action, and special risks associated with training.

Thomas Gutheil, M.D. will then engage the audience in a discussion of "Boundary Issues in Clinical Practice." Using vignettes drawn from his experience consulting in forensic psychiatric cases and interacting with boards of registration, Dr. Gutheil will illustrate common boundary dilemmas and effective responses to them. Sample topics will include self-disclosure; gifts; physical contact; seeing patients at odd hours; interacting with patients outside the office; the "slippery slope" from minor boundary crossings to sexual misconduct; and boundaries as viewed by courts and by boards of registration.

Caleb Korngold, M.D. will present a response focused on boundary issues in professional mental health training. Vignettes from residents' experience at the Harvard Longwood Psychiatry Training Program will be featured. Sample dilemmas will include handling adverse outcomes; the role of supervision; communication with insurance providers; termination; e-mail communication; and social media.

WORKSHOP 46

INCARCERATION OF BLACK MALES: THE EFFECTS OF UNTREATED BIPOLAR, ADHD, AND SUBSTANCE ABUSE DISORDERS

Chairs: Napoleon Bonaparte Higgins Jr, M.D., Ericka Goodwin, M.D.

Presenters: Johnny Williamson, Timothy Benson, Rahn K. Bailey, M.D., Otis Anderson III, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Discuss racial disparities in diagnosis, treatment options, and research in multicultural populations related to Bipolar Disorder, ADHD and Substance Abuse Disorders.; 2) Participants should be able to understand the differences in the rates of incarceration of black males in comparison to males of other ethnic backgrounds, and how governmental policies helped promote these disparities.; 3) Identify how impulse control and behavior disorders are inappropriately treated in the legal and criminal justice systems.

SUMMARY:
ADHD, Bipolar Disorder and Substance Abuse Disorders are neurobehavioral disorders that are characterized by impulsivity, poor decision making, anger, inattention and odd behavior. This presentation will discuss evidence-based practices and interventions in decreasing black male incarceration rates. The alarming rate of incarcerated mentally ill African-American males goes largely ignored and inadequately researched; which leads to inappropriate treatment of black males via the legal system. This has a major impact on African-American communities, as well as their families. Mandatory prison sentences and "The War on Drugs" for people with drug offences have forced substance abusers into incarceration without provisions for substance abuse treatment. There are unique differences in metabolism among various cultural populations that impact the differential effects of psychotropic medications. Many jails and prisons have replaced psychiatric hospitals

and house many persons with the severest forms of mental illness. Participants will be able to identify how black males with co-morbid mental illness and substance abuse are receiving inappropriate care in incarcerated settings. There is currently limited focused study on the specific effects of psychiatric medications in African-Americans. This talk will focus on basic psychopharmacology and drug classes in the treatment of bipolar disorder and ADHD in African-American men.

WORKSHOP 47

THE FEDERAL AFFORDABLE CARE ACT IN ACTION: IMPLEMENTATION OF HEALTH HOMES IN NEW YORK CITY

Chairs: David C. Lindy, M.D., Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the concept of health homes and their relationship to Medicaid redesign in New York State; 2) Understand the relationship between health homes and increased integration of psychiatric and medical care; 3) Understand the role of the psychiatrist as a leader of the health home team.

SUMMARY:
In 2010 the Federal government passed the Affordable Care Act, which included a provision for building person-centered systems of care to achieve improved outcomes for Medicaid beneficiaries and increased savings for State programs. This model is known as "Health Homes." In New York State (NYS), Medicaid serves over 5 million enrollees, nearly 300,000 of whom have serious mental illness (SMI), often co-occurring with substance abuse, HIV/AIDS and chronic health conditions. It is well known that people with SMI die on average 25 years earlier than the general population, and that these deaths are primarily related to chronic medical illnesses. This is compounded by high rates of metabolic syndrome among the SMI. Thus, the SMI group is a primary driver of high volume costly services, including repeat inpatient hospital stays and frequent emergency department visits. In 2011, NYS Department of Health (DOH) redesigned Medicaid service delivery to implement Health Homes statewide, facilitated by an increase in the Federal Medicaid match from 50 to 90 percent. This shift is designed to improve patient outcomes through better coordination of care and greater cost effectiveness.

In early 2012, the Visiting Nurse Service of New York (VNSNY) was identified as a lead Health Home by NYS DOH, in partnership with eight other hospital and community based medical and mental health providers in New York City. With over 25 years' experience serving the SMI population, VNSNY is uniquely positioned to leverage the array of health care providers within our health home network. Our goal is to improve psychiatric and medical care for patients in our health home, including the reduction of the incidence of metabolic syndrome and type 2 diabetes, effecting nearly 1/3 of our population. This workshop will present preliminary findings from the first six months of the VNSNY Health Home implementation, including development of our clinical service model, issues related to start-up, and clinical and quality indicators. We seek to discuss our experience with other clinicians, administrators, and policy experts involved with the implementation of health homes in their parts of the country.

WORKSHOP 48

IMPLEMENTING SERVICES FOR VULNERABLE POPULATIONS ACROSS SYSTEMS: THE HOUSING FIRST EXAMPLE

Chairs: Nicole Kozloff, B.A., M.D., Christina J. Arredondo, M.D.

Presenters: Sam Tsemberis, Ph.D., Vicky Stergiopoulos, M.D., M.H.S., Lara C. Weinstein, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the basic components of Housing First and its adaptation to meet the needs of local contexts; 2) Consider the role of Integrated medical and behavioral clinical care, program development, and research in a program for vulnerable populations; 3) Summarize the development and outcomes of an ethnoracial adaptation of Housing First to meet local needs; 4) Reflect on the systemic factors that may influence outcomes of programs that serve vulnerable populations and key ingredients for success across systems.

SUMMARY:
Housing First is a complex intervention that provides immediate access to housing and supports to individuals with severe mental illness who are homeless without requiring treatment or sobriety. Beginning in New York City in the 1980s, Housing First initiatives have now been implemented across the United States and Canada, as well as Japan, the Netherlands, Spain, and Portugal. Pathways to Housing, led by Dr. Sam Tsemberis, have driven the dissemination of this model and the development of its evidence base. Dr. Nicole Kozloff and Dr. Christina Arredondo will describe a brief history of Housing First, which subsequent presenters will use as an example of the challenges and lessons learned from implementing services for vulnerable populations across different systems and local contexts. Pathways to Housing-PA was started in 2008 at the request of the City of Philadelphia to help end the problem of chronic homelessness. Dr. Lara Carson Weinstein, Assistant Professor in the Department of Family and Community Medicine at Thomas Jefferson University, has worked with Pathways-PA to create a program that fully integrates medical and behavioral healthcare in the areas of clinical services, population-based screening and prevention, quality improvement, and community-based participatory research. She will describe the development of the program and present preliminary data on health status and quality improvement initiatives. Dr. Vicky Stergiopoulos is a clinician researcher at the Toronto site of At Home/Chez Soi, a 4-year Mental Health Commission of Canada study comparing Housing First with treatment as usual across 5 cities in Canada, paired with one of 3 interventions: assertive community treatment (ACT), intensive case management (ICM), or a locally-developed intervention. Dr. Stergiopoulos worked on the development of an ethnoracial ICM intervention targeting racialized communities to meet the needs of the city's diverse population. She will describe the Canadian context from which At Home/Chez Soi emerged, and specifically, the development of the ethnoracial intervention as an anti-racism/anti-oppression model to meet local needs, along with results of early field trials. Finally, Dr. Tsemberis, having developed Housing First and overseen its implementation across disparate jurisdictions, will discuss the reciprocal influence of local contexts on the model, examples of how systemic factors can lead programs to thrive or to struggle, and key ingredients for successful program implementation across systems.

WORKSHOP 49

TRUSTIN' WISE' OLE' OWLS: RACIAL STRESS, COPING, & SOCIALIZATION IN BLACK FAMILIES

Chair: Howard Stevenson, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand how racial stress and conflict is relevant to the experience of trauma; 2) Learn a theory that explains racial stress, coping, and socialization for youth and families; 3) Learn how racial stress and socialization are faced in family therapy with families of color; 4) Learn unconventional, culturally relevant, developmentally appropriate, gender-specific strategies with youth and families.

SUMMARY:
Racial socialization is defined as the transmission and acquisition of intellectual, emotional, and behavioral skills to affirm and protect individual & collective racial self-efficacy for the reappraisal & negotiation (literacy) of racially stressful encounters. This workshop will discuss how this process is relevant to the theory and practice of novel culturally relevant therapy approaches to address trauma in Black youth and families. Recast theory is proposed as a model to reframe stress and trauma as workable realities during public interactions that take place in barbershops, basketball courts, school classrooms and therapy sessions.

WORKSHOP 50

EDUCATING FUTURE PSYCHIATRISTS: A LOOK AT OUR ROLE IN INTEGRATED HEALTHCARE

Chair: Aniyizhai Annamalai, M.D.

Presenters: Aniyizhai Annamalai, M.D., Michael J. Sernyak, M.D., Hassan M Minhas, M.B.B.S., M.D., Robert M. Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize the changing role of psychiatrists in patient centered integrated health care; 2) Identify the benefits and disadvantages of enhancing physical health education of psychiatrists; 3) Understand the effects of a shift in psychiatry training in everyday practice.

SUMMARY:
There is increasing momentum for providing patient centered care integrating both physical and mental health. This is especially relevant for persons with serious mental illness who are dying about 25yrs earlier than the general population, mostly of natural causes. For patients in the public health sector, the mental health center is often the only point of contact with the health care system. With the rapid changes in our field, there is an increasing need for psychiatrists to be aware of conditions that result from psychiatric treatment and provide counseling in preventive health care.

Psychiatry residents spend 4-6 months in their first year in primary care, as per the Accreditation Council for Graduate Medical Education (ACGME) guidelines. However this time is usually not tailored to the specific needs of psychiatry residents. Also, there is no enhancement of these skills during later years of residency. Several models for enhanced medical training in psychiatric residency have been proposed. There is also increasing amount of physical health related educational material for practicing psychiatrists at educational conferences.

However, there are several factors to consider while implementing these curricular changes. This would mean a shift in the culture of psychiatric practice. Even among proponents of increased role of psychiatrists in physical health, there is no consensus on the nature, extent, and timing of this training. It has not yet been proven that enhanced physical health training translates into improved health for our patients. There are other potential concerns such as reduced emphasis on other traditional areas of psychiatry.

In this workshop, we propose to discuss both the benefits and costs of enhancing physical health training of psychiatrists. We will start with a case presentation illustrating the

importance of integrated health care. Multiple perspectives including those of a practicing psychiatrist, resident in training, residency program director and the director of a community mental health center will be presented.

WORKSHOP 51

DISASTER RESPONSE FOR PEOPLE AFFECTED BY SUPERSTORM SANDY IN NEW YORK CITY

Chairs: David C. Lindy, M.D., Neil Pessin, Ph.D.

Presenters: Deirdre DeLeo, L.C.S.W., M.A., Thomas G. Laverack, L.C.S.W.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Understand the magnitude of the disaster response requirements associated with Superstorm Sandy; 2) Appreciate the issues involved in an organization's multi-system, large scale disaster response; 3) Understand the role of crisis counseling as a post-disaster mental health response.

SUMMARY:
In late October, 2012, Superstorm Sandy hit the mid-Atlantic, devastating huge areas of the coast. Many thousands of people suffered severe damage to homes, businesses, and property. The estimated cost of the storm is expected to be at least $75 billion. The Visiting Nurse Service of New York (VNSNY) provides home care and home-based mental health services to approximately 35,000 New Yorkers per day. In the immediate aftermath of the storm there were vast areas of the city that were flooded, without power, and impassable. Many people were homeless, dislocated, or trapped on high floors of apartment buildings without elevator service. VNSNY utilized its disaster management program to organize the effort to locate and provide services to thousands of patients in storm affected areas. In addition, VNSNY is participating in Project Hope, a joint initiative between federal, state, and city agencies, to provide crisis counseling to people in storm affected areas of New York City. This program is designed to identify people experiencing post-traumatic effects of the disaster, help them to normalize their experience, and provide referrals and further assistance as indicated. Starting in December, 2012, it utilizes lay counselors who do door to door outreach in the high risk areas. These counselors are supervised by clinical personnel, and all staff have participated in a specialized training developed by the Federal Emergency Management Agency. We will present preliminary findings from the VNSNY and Project Hope experiences with this unique disaster. The workshop will encourage discussion from audience participants interested in sharing disaster work experiences related to Sandy or other disasters.

WORKSHOP 52

PUTTING RECOVERY INTO PRACTICE WORLDWIDE: INTERNATIONAL PERSPECTIVES ON RECOVERY ORIENTED CARE

Chair: Kenneth S. Thompson, M.D.

Presenters: Inger-Kari Hagene Nerheim, Alan Rosen, D.P.M., M.B.B.S., Matthew O. Hurford, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe how recovery oriented practice is being introduced in Australia, Norway and the USA; 2) Distinguish between the models of recovery oriented care in each country; 3) Consider the barriers to and opportunities for the implementation of recovery oriented care in different countries; 4) Discuss what countries might learn from each other as they implement changes in psychiatric services.

SUMMARY:
The concept of recovery is sweeping much of the developed world and starting to elicit a response from the psychiatric profession. Initiatives to "put recovery into practice" are developing in many countries. This presentation will focus on the work to implement recovery oriented practice in Australia, Norway and the USA (Philadelphia), The challenges and the barriers to "creatively destroying" the legacy approach to psychiatric care are substantial, as is the dilemma of determining what elements of practice are essential in supporting a recovery oriented approach. This session will examine in detail what is happening in the three sites. Discussion will focus on what might be learned from an ongoing international dialogue about recovery oriented care.

WORKSHOP 53

INCARCERATION OF BLACK FEMALES: CASUALTIES AND COLLATERAL DAMAGE FROM "THE WAR ON DRUGS" AND OTHER NON-VIOLENT OFFENCES.

Chairs: Napoleon Bonaparte Higgins Jr, M.D., Stephen McLeod-Bryant, M.D.

Presenters: Michelle Clark, Monique Upton MD, Aikiesha Shelby, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) This workshop will examine the acute increase and mass arrest of drug crimes which have targeted African-American women over the past decade.; 2) Participants will be able to evaluate evidence-based intervention and diversion programs for women that are effective in keeping families together.; 3) Participants will understand the racial divide in rates of incarceration and the sequelae of how this has damaged African-American communities becoming a public epidemic and health concern.

SUMMARY:
There has been a rapid increase in the arrest and incarceration of African-American women over the past 15 years. Incarceration of women causes unique issues within communities and families due to disruption of the home. In 70% of African-American homes the mother is the sole and only provider. This presentation will take a close look at the balance of cost on the American public to incarcerate non-violent offenders including the court cost, legal fees, and social services provided for the children and families. Much of this has occurred since the national attention to the "War on Drugs." The fact that African-American communities have lower drug use rates and higher incarceration statistics than most other communities, begs the question, "Why this disturbing trend is occurring"? According to the Bureau of Justice Statistics, black women are being incarcerated at a rate of twice that of Hispanic women and 5 times the rate white women. Most of these crimes are non-violent offenses. While the incarceration numbers of men are higher than women, women are being incarcerated at a higher rate than men and male incarceration rates are slowing. Jim Crow laws and "separate but equal" has been abolished, it is clear that incarceration is becoming the second most public detriment to blacks in America, only second to enslavement. By the end of this discussion participants should be able to understand the public epidemic of black female incarceration and the dire implications it has on the black community.

WORKSHOP 54

THE NARRATIVE PSYCHIATRY TOOLKIT: STRENGTHS-BASED, COLLABORATIVE PRACTICES THAT PROMOTE RECOVERY

Chair: SuEllen Hamkins, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Use narrative principles and practices to help patients discover and cultivate their strengths and values as resources for recovery; 2) Conduct thorough, strengths-based initial psychiatric consultations ; 3) Explain how externalizing and deconstructing problems and seeing problems as separate from the patient's identity can constrain symptoms and contribute to positive identity development; 4) More fully honor patients' values and preferences in making medication and other treatment decisions, even when the patient's judgment is impaired by the problem they are facing; 5) Create strengths-based medical records that meet professional documentation standards.

SUMMARY:
Narrative psychiatry offers powerful yet nuanced strategies for collaboratively discovering and cultivating patients' strengths and values. This workshop explains principles and practices of narrative psychiatry that can be put to immediate use to foster more effective collaborative, strengths-based patient-care across a variety of settings. Specific narrative strategies that will be taught include conducting strengths-based initial psychiatric consultations, externalizing and deconstructing problems, developing histories of success, eliciting strengths-based family histories, co-authoring narratives of preferred identity, cultivating communities of support, creating empathic, culturally-attuned therapeutic relationships, creating collaborative treatment plans, and constructing strengths-based medical records and other therapeutic documents. Drawing inspiration from narrative therapy, narrative psychiatry offers a wealth of novel therapeutic tools that promote more effective person-centered, recovery-oriented treatments that help patients overcome mental health challenges and create lives and relationships that are satisfying.

WORKSHOP 55

THE "FUTURE OF PSYCHIATRY" PROJECT: BACKGROUND, RATIONALE, AND PROGRESS TO DATE

Chairs: Michael A. Flaum, M.D., Hunter L. McQuistion, M.D.

Presenters: Kenneth S. Thompson, M.D., Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify and describe at least 2 factors that suggest the need for a fundamental paradigm change in the way that psychiatry defines itself and is routinely practiced today; 2) Identify at least 2 examples of innovative practices that may serve as models for such a paradigm shift; 3) Identify and describe at least 2 changes in psychiatry residency education that are necessary to meet the changing health care environment.

SUMMARY:
Recognizing fundamental flaws in the fragmented US mental health care systems and the potential of an integrative, recovery-oriented approach, the leadership of the American Association of Community Psychiatrists initiated the Future of Psychiatry project in 2012. This project is modeled on a similar initiative undertaken by the leadership of several family medicine organizations in the early 2000's, which is now being successfully implemented. The goal of the project is to develop a strategy to transform and renew the discipline of psychiatry to meet the needs of patients in a changing health care environment. This symposium will provide

the rationale, process and progress to date of this initiative and seek input from the audience participants regarding its future direction.

WORKSHOP 56

RECOVERY TRANSFORMATION AS IMPROVED CUSTOMER SERVICE: "WERE YOU TOTALLY SATISFIED WITH YOUR EXPERIENCE TODAY?"

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

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Define customer service, customer experience and customer satisfaction and their applicability to health services; 2) Describe the potential impact of excellent customer service on the goal of delivering high quality recovery-oriented behavioral health services; 3) Identify improvements that can be made in his/her own workplace to improve the experience and satisfaction of service users.

SUMMARY:
A notable recent development in the rapid evolution of healthcare in North America is a focus on customer service. Borrowing from lessons learned in other service-oriented sectors, hospital administrators have begun to target high patient satisfaction as a way of increasing customer loyalty and improving sales and profits. We argue that patient satisfaction is also a critical and under-emphasized dimension of quality in public sector behavioral health, where asylum-era attitudes toward service users frequently persist. In this interactive workshop, we will describe the concepts of customer service, customer experience and customer satisfaction by drawing on examples from participants' everyday experiences as customers. Next we will review the academic literature on patient satisfaction in healthcare, highlighting its potential value and also the conceptual and methodological problems that remain. We will then consider how a customer service focus can facilitate the transformation of behavioral health to a recovery orientation. Our experiences at the Connecticut Mental Health Center (New Haven, CT) and the Centre for Addiction and Mental Health (Toronto, Canada) will serve as a springboard for discussing 10 tips for improving quality of care by improving customer service. Finally, participants will work in small groups to develop customer service innovations for their own workplaces.

SUNDAY, OCTOBER 13, 2013

WORKSHOP 57

EMERGENCY PSYCHIATRY IN HEALTHCARE REFORM: REDUCING COSTS, IMPROVING CARE

Chair: Scott Zeller, M.D.

Presenters: leslie zun, M.B.A., M.D., Avrim B. Fishkind, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Identify ways that emergency psychiatry is partnering with emergency medicine to improve crisis care; 2) Recognize how telepsychiatry in the ER can improve access to care and reduce unnecessary inpatient admissions; 3) Be familiar with innovative community crisis alternatives to medical emergency departments.

SUMMARY:
Health Care Reform seeks to improve quality and access to care while controlling costs. Emergency Psychiatry has the potential to contribute significantly to these goals, by providing timely, effective and non-coercive interventions for those in crisis, while helping to avoid unnecessary and expensive psychiatric hospitalizations.

The workshop will open with a brief review of the aims of Health Care Reform, and the ways that Emergency Psychiatry is well-positioned to participate. Then Leslie Zun, MD, Chair of Emergency Medicine at Chicago Medical School, will present on how Emergency Psychiatry and Emergency Medicine are partnering to provide timely mental health treatment in the emergency department (ED). Next, Avrim Fishkind, MD, of JSA Health, will discuss how telepsychiatry in the ED can improve access to care and reduce inpatient admissions. To conclude, Scott Zeller, MD, of Alameda Health, will describe innovative community alternatives to the ED for patients in mental health crises.

There will be ample time reserved for audience questions and discussion.

WORKSHOP 58

RISK MANAGEMENT AND LIABILITY, AND CLINICAL ISSUES WITHIN THE INTEGRATED CARE SETTING

Chair: Kristen Lambert, J.D., M.S.W.

Presenters: Lori E. Raney, M.D., Katherine Hobbs Knutson, M.D., D. ANTON BLAND, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Risk management and liability issues within the integrated care model including identifying formal and informal consultations; 2) The roles within the integrated care model and its potential impact on liability; 3) Discuss case examples within the integrated care model; 4) Identify risk reduction strategies .

SUMMARY:
The emergence of ACOs and Integrated Care has brought about new ways to look at how patients with psychiatric issues are being treated. There may be multiple medical and non-medical providers involved with the overall patient care. This 1.5 hour workshop will outline some of the risk management and liability issues to consider when working in the integrated care setting. Risk reduction strategies will be identified. Psychiatrists on the panel will discuss real life case examples when working in the integrated care setting and how determining the role of the psychiatrist within the model is an important consideration. Panelists will discuss their involvement on the APA integrated care work group and will discuss issues considered when developing a liability primer on integrated care.

WORKSHOP 59

BEHAVIORAL HEALTH SERVICES WITHIN AN IMMIGRANT COMMUNITY: A POPULATION HEALTH PERSPECTIVE FROM A STUDENT-RUN FREE CLINIC

Chair: Andres Barkil-Oteo, M.D., M.Sc.

Presenters: Marco A. Ramos, B.A., Michelle Alejandra Silva Psy.D., Psy.D., Andres Barkil-Oteo, M.D., M.Sc., Robert M. Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Describe the concept of psychoeducation and its role in mental health promotion and prevention of mental illness; 2) Define the role of a supervised medical student as facilitator of a psychoeducation intervention; 3) Understand some of the challenges and strategies for delivering behavioral health interventions within a medical student run primary care clinic. .

SUMMARY:
The HAVEN Free Clinic Behavioral Health (BH) Program for Depression is an American Psychiatric Association-funded initiative (A Helping Hands grant) in which supervised health professional students provide mental health services to uninsured, largely undocumented, Spanish-speaking immigrants. In alignment with the World Health Organization Mental Health GAP guidelines, this program provides first-line services including: 1) psychoeducation, 2) reduction of psychosocial stressors, and 3) modified behavioral activation exercises to patients with mild-to-moderate depression. To address the lack of specialist mental health providers available to the immigrant community, these services are provided by Yale University medical student volunteers trained and supervised by an interdisciplinary team of psychiatrists and psychologists. The BH Program provides this population with free services grounded in a population mental health approach that focuses on the promotion of mental health and prevention of mental illnesses.

In the BH Program, Spanish-speaking health professional student volunteers administer an individualized psychoeducational curriculum that is delivered one-on-one and is based on the Promotora [community health worker] manual developed at the University of California, Berkeley. This psychoeducation curriculum targets common acculturative stressors associated with the Latino/a immigrant experience in the United States. In addition, medical student facilitators promote patient behaviors (e.g. exercise, reactivation of social networks) that are associated with psychological health. Finally, volunteers in the Social Services department at HAVEN target psychosocial stressors by connecting patients with community resources. To prepare students to participate in the program, psychologists and psychiatrists train medical students in the principles of motivational interviewing and common strategies for engagement, population health, quality improvement methods, and psychoeducation.

The immigrant community of Fair Haven, CT has limited access to mental health services. This situation is projected to worsen in the coming years.4 Through medical student involvement, the BH Program for Depression serves as a model for rational task shifting,5 expanding access to mental health services to undocumented immigrants, and increasing medical student interest in community psychiatry.

Within this workshop we will discuss the details of the BH project as delivered by healthcare students. We will present project data and insights from faculty and students who have participated in the initiative. Group discussion will focus on some of the challenges and strategies for implementing similar projects within a student-run clinic. Workshop participants will identify potential ways to overcome difficulties of implementation and to develop strategies to engage students and faculty in the process of designing and delivering BH services.

WORKSHOP 60

BEYOND THE RESEARCH: REPRODUCTIVE MENTAL HEALTH IN PRACTICE

Chair: Elyse D. Weiner, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Demonstrate a knowledge of utilizing the principles of basic reproductive mental health in an office setting; 2) Demonstrate a knowledge of formulating ways to speak with patients about the risks and benefits of various psychopharmacologic treatments in pregnant and lactating patients; 3) Demonstrate a knowledge of creating treatment

plans that are more understandable for the patients based on available research in reproductive mental health field.

SUMMARY:
Have you ever left a pregnancy and postpartum psychopharmacology lecture feeling scared and confused? There is so much research out there but how do you understand enough of it so it makes sense to you? Can you digest a sufficient amount to bring it to your patients in a way that's comprehensible? What do you actually do when pregnant patients are in your office? For many clinicians, who are not in a research or clinic setting, they can feel out on a limb when a pregnant or lactating patient comes into their office. Many of us do not have a colleague to curbside when the going gets rough and the data difficult to interpret. As a consultation liaison psychiatrist and seasoned private practitioner, Dr. Weiner developed this workshop to help others who often attend lectures where they feel overwhelmed by research statistics. Together, we will talk about strategies of how to apply scientific knowledge to the patient in the office.

This workshop will review how to incorporate basic research in the reproductive mental health field into the clinical setting. First we will focus on the clinical issues of dealing with expectant and lactating mothers. The didactic portion will focus on familiarizing patients and practitioners to the area of reproductive mental health, which is essential in providing patients with the psycho-educational background they need to proceed through their pregnancy. We will review some of the medications, how to explain the risks and benefits, as well as disease states seen in these populations such as depression, anxiety disorders, and bipolar disorder. Using clear language, we will translate research into concepts that are more patient oriented, in order to distill what some of these risks truly mean to a patient and her child. The goal of this workshop is to bring the principles of reproductive mental health into useful practice.

WORKSHOP 61

CREATING AN OUTCOMES MANAGEMENT SYSTEM WITHIN AN ACADEMIC COMMUNITY MENTAL HEALTH CENTER

Chair: Shane W. Rau, M.D., Ph.D.

Presenter: Gary Cuddeback, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Discuss the concept of an Outcomes Management System; 2) Discuss an example of the development of an Outcomes Management System based on the experience of an academic community mental health center; 3) Describe the expertise, funding and leadership resources needed to develop an Outcomes Management System; 4) Develop a Logic Model and begin exploring needed resources for the development of an Outcomes Management System.

SUMMARY:
The Center for Excellence in Community Mental Health at the University of North Carolina at Chapel Hill is developing an Outcomes Management System (OMS) with the goal of creating, managing, and utilizing clinical, administrative, and stakeholder data to provide quality improvement (QI), clinical research and health services research infrastructure. Our center encompasses a number of outpatient, inpatient, and community-based physical – and behavioral-health services. We believe our experiences can be instructive to colleagues who are in the planning or development process for similar systems. We propose a workshop that will: (1) describe our concept of an OMS, (2) describe our early experiences in developing an OMS including our challenges and achievements to date, (3) describe the requisite funding, infrastructure, expertise, and leadership resources and (4) include a facilitated group exercise to help participants develop or improve their own OMS.

Outcomes evaluation is a system which evaluates clinical, administrative, and stakeholder outcomes data. Outcomes management collects, organizes and redistributes the outcomes data for use by stakeholders. We have been working to develop an organizing Logic Model, to determine a common set of required data, an efficient system of collecting data, and a system of organizing and redistributing the data in a way that is meaningful, secure, and flexible. Our process began with a "paper and pencil" annual assessment packet used by psychiatric residents to gather information about patients' community functioning, medical / health status, and service utilization. We discovered this process, though useful, was overly burdensome and inadequate. In turn, we have partnered with university resources to automate collection of a portion of required information directly from the medical record as well as administrative and billing data systems. Also, we have developed more efficient data collection tools that are integrated into usual clinical work. In addition, we are developing a system of information distribution that is timely, organized, and secure. Our center's stakeholders include center, department and university administration, policymakers, consumer groups, center staff and clinicians as well as our patients and their families. We believe our stakeholders will benefit from pertinent, readily available data for decision making in their role with the center with resulting improvements from the level of the individual mental health consumer to the broader mental health system of care.

We will describe our process to date, requisite expertise, costs, and infrastructure, and will highlight achievements as well as challenges in the development process. We will also conduct an audience participation exercise in which participants develop and discuss a Logic Model for an OMS. We believe this will help participants consider and explore needed resources for an OMS in their own work settings.

WORKSHOP 62

DOCTORS AS PATIENTS: PSYCHIATRIC TREATMENT OF WOMEN PHYSICIANS AND GAY AND LESBIAN PHYSICIANS

Chair: John S. Martin-Joy, M.D.

Presenters: Marshall Forstein, M.D., Mary K McCarthy, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Recognize typical psychological strengths and vulnerabilities of physicians; 2) Describe commonly encountered clinical issues and effective approaches in the treatment of gay and lesbian physicians; 3) Describe the impact of trauma in female physicians and the adaptive and defensive function of dissociation; 4) Identify effective clinical approaches to working with dissociation in female physician-survivors.

SUMMARY:
Dedicated to the care of others, idealized yet chronically stressed, physicians enter the role of patient with a signature combination of strength and vulnerability. Treating doctors can be daunting for clinicians. As research began to reveal during the so-called "golden age" of medicine, physicians are more likely than other professionals to have endured painful childhoods, to have difficulties with intimacy, to misuse prescription drugs, and to die by suicide. As previously underrepresented groups have entered medicine, psychiatrists have begun treating doctors who are in these underrepresented groups and who have unique issues to address.

This workshop will present a lively discussion of two groups poorly served by the traditional culture of medicine: gay and lesbian physicians, and women physicians--particularly those with a history of trauma. Little guidance is available for the psychiatrist who seeks to treat these physicians. Our goal is to help psychiatrists identify the strengths and vulnerabilities of these doctors, and to approach their treatment more effectively.

John Martin-Joy, M.D., will introduce the topic by reviewing physician development and vulnerability over the life span, as well as key clinical issues in the treatment of physicians.

Marshall Forstein, M.D., will discuss "Working with Gay and Lesbian Physicians." Until homosexuality was removed from the DSM in 1973, gay and lesbian physicians faced overt bias involving their sexual orientation; today, these physicians continue to face unique challenges at work and at home. Dr. Forstein will engage the audience in a discussion of vignettes from his experience treating gay and lesbian physicians, as well as in training and mentoring gay and lesbian residents. Sample topics will include sexual identity, coming out to self and others, intimacy, depression and substance abuse, discrimination, and internalized homophobia.

Mary McCarthy, M.D., will discuss "Working with Trauma and Dissociation in Female Physicians." In 1975 there were few women in medicine, and those few faced pervasive discrimination; today women account for more than half of medical students and have profoundly altered the culture of medicine. Many woman physicians also have personal experience of childhood trauma. Dr. McCarthy will discuss dissociation as an adaptive and a defensive mechanism, linked to early traumatic disruptions of connection and to experiences of overstimulation. At times medical training requires that trainees split off their feelings; physician-survivors may do well at work when their dissociative defenses function adaptively. But problems arise when dissociation interferes with intimacy and psychological wholeness. Using vignettes from her experience treating women physicians, Dr. McCarthy will show how clinicians can facilitate their physician-patients' recovery and reintegration.

WORKSHOP 63

MAKING THE NECK: LESSONS FOR ENHANCING PRIMARY CARE WITH BEHAVIORAL HEALTH SERVICES IN A FEDERALLY QUALIFIED HEALTH CENTER

Chair: Kenneth S. Thompson, M.D.

Presenters: Julanne Bibro-Ruch, L.C.S.W., Katie Fitzsimmons, M.S.W., Andrea Fox, M.D., Joni Schwager

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1) Discuss the challenges of enhancing primary care services with behavioral health care; 2) Describe the role of mental health professionals integrated into the primary care setting of an FQHC; 3) Appreciate the utility of creating a structure screening and tracking programs for depression and substance abuse in an FQHC.

SUMMARY:
Efforts to integrate medical care and behavioral health to create a more wholistic and enhanced approach to primary care have gained a great deal of attention recently, fueled by the awareness that the foundation of all effective health care systems is their capacity to deliver excellent primary care. It has not been a simple thing to bring the two divergent

cultures of medical care and behavioral health care together. Multiple strategies have been tried. The first attempts focused on how primary care and behavioral health providers coordinated the care of their mutual patients. Schemes tried included enhanced referrals between providers, co-location of providers and integration of providers. It became clear rather quickly that integration produced the best outcomes, promoting. But the problem of detecting psychiatric problems in individuals and tracking their care over time has persisted. A new approach is now being tested by AHRQ, building on the IT revolution – the use of structured screening and registry programs to systematically identify, treat and track individuals with psychiatric challenges common to primary care settings, such as depression and substance abuse. Members of the clinical staff of a Federally Qualified Health Center in Pittsburgh will describe the clinical model they have developed to both integrate care and implement a screening, treatment and tracking program for depression and substance abuse, supported with funds from a local foundation and through participation in the AHRQ funded Partners in Care initiative. Implications of the model for further efforts at putting integrated care together will be explored.